STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235171	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Grand Blanc	3139 East Baldwin Road Grand Blanc, MI 48439

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents were treated with dignity and respect, failing to follow the care plan for a visually impaired resident by failing to describe meals when served, and failing to ensure that call lights were in reach or respond to resident call lights in a timely manner and not provide explanations when resident asked questions about their medications, identified for six residents (R72, R76, R86, R98, R128, R143) of seven residents reviewed for dignity, and a confidential group of residents. Resident #86 (R86): During the observation tour conducted on 09/23/25 at 11:00 AM, R86 was lying in bed and asked for some water. When surveyor ask if he had asked and if he was using his call light? He said he was not able to find them. R86 further explained that he was partially blind and that he was not able to find his call light. R86 indicated that he needed some water to drink and he thought I came to bring some fresh water pointing out that two cups were empty by his bedside. While searching for his call light button, R86 call light was found on the floor under his bed. He revealed he was blind on one eye and couldn't see very well. The Director of Nursing (DON) was in the hallway on 9/23/25, at 11:05 AM, and was asked if staff can get R86 some fresh water (if R86 did not have fluid restrictions) and that his water cups were empty, and the call button was found on the floor. The DON confirmed that R86 did not have fluid restrictions. R68 was observed sipping fresh water after DON prompted the staff on 9/23/25 at 11:07 and said Thank you to the surveyor. R68 was noted positioned at bedside within reached by R68. A review of Electronic Medical Record conducted on 9/23/25 at 1:57 PM revealed, R86 was [AGE] years old, admitted to the facility since 12/02/22 with the diagnosis of Major Depressive Disorder, Alzheimer's Disease, Type 2 Diabetes Mellitus and Generalized Anxiety Disorders in addition to other diagnoses. R86 Brief Interview of Mental Status (BIMS) Score was 07/15 assessed on 7/22/25. A score of seven means severe cognitive impairment. Minimum Data Set Section GG assessed on August 5, 2025, revealed R86 was dependent on staff with toileting, and required a two-person transfer assistance. R86 Care plan was reviewed and revealed that R86 was legally blind in his left eye and had hearing loss. Some interventions were to encouraged fluid intake for R68 as ordered and reinforce the need to call for assistance to prevent/minimize the risk for falls or accidents. Resident #128 (R128) A review of R128's medical record revealed an admission on [DATE] with diagnoses that included (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dementia, diabetes, respiratory failure, and stroke. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 9/15 that indicated moderately impaired cognition and the Resident needed substantial/maximal assistance with bathing, upper body dressing, personal hygiene, roll left and right and was dependent on a helper for toileting hygiene, lying to sitting, and transfers. On 9/23/25 at 10:49, an observation was made of Resident #128 lying in bed. The head of the bed was elevated slightly. The Resident had a meal tray on an overbed table in front of her. The meal had been eaten. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about the care she received at the facility and if she had any concerns. The Resident reported she had been waiting to get checked and changed this morning. The Resident was asked if she had been changed before breakfast was brought in and the Resident reported the breakfast came before they checked and changed for incontinence. The Resident indicated she thought she had a bowel movement. The Resident reported that she was waiting for staff to come back to get the breakfast tray and get changed but no one had been in. The Resident was asked what time her breakfast tray had been received and the Resident stated, 8:45 I think. It doesn't take me that long to eat. The Resident was asked where her call light was and if she had used it. The Resident reported she did not have her call light and thought it might be up at the top of the bed. An observation was made of the call light clipped to the fitted bedsheet at the corner of the mattress on the side of the mattress and not in reach for the Resident. The Resident reported she had pulled her pillow from underneath her head hoping the call light was attached to the pillow, but reported it was not on her pillow. An observation was made of the Resident without a pillow, the Resident reported it had fallen to the floor when she was trying to see if the call light was attached to the pillow. When asked if she had issues with the call light not being placed in reach, the Resident reported it has happened before, sometimes it has been attached to the pillow or where she can't find it and stated, I like it right here on this pocket, that's where it is supposed to be clipped. The Resident reported that she had rolled off the bed before and hurt her knee. She reported she could not reach up to the top of the mattress with her left hand because she could not move it well and if she were to reach over to try to find it with her right hand, she reported being afraid of rolling off the bed. The Resident stated, I have been waiting for someone, I can't get my light. The Resident reported she had finished her breakfast around 9:00 AM. On 9/23/25 at 11:13 AM, an interview was conducted with Nurse EE who had gone to find the CNA who was taking care of R128. The Nurse was unable to find the CNA and came into the room. The Nurse was asked about the call light not in reach for the Resident. The Nurse reported the call light should be placed in reach for the Resident, unclipped the call light from the upper side corner of the fitted sheet and placed it where the Resident described she wanted it, which was on the chest pocket of the Resident's gown. The Nurse indicated that the breakfast trays should have been picked up out of the Resident's room and indicated trays come for breakfast about 8 to 8:30 in the morning. The Resident requested that she get changed. On 09/23/2025 at 11:56 AM until ~(approximately)12:28 PM During dining observation, CNA BB was observed standing at the front of the staff line near the kitchen service area. CNA BB paced back and forth in front of the dining area toward the service line while yelling out, 608, 609, 604, and then a resident's name toward the service line. Staff were not addressing residents in a dignified respectful manner. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a review of R72's medical record, the resident was admitted to the facility 08/26/2025 for skilled nursing care related to a fracture of the left femur, diabetes mellitis type 2 (insulin resistance causing elevated blood sugar) and chronic obstructive pulmonary disease. A review of R72's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Additional medical diagnoses included glaucoma (impaired vision) and anxiety. On 09/23/2025 at 11:56 AM until ~12:28 during dining observation, R72 was served her meal from the opposite side of the table by CNA I. CNA I initially attempted to serve the meal to a different resident and, after being redirected by several dining residents to R72's location, CNA I reached over the top of a resident and placed the meal plate down in front of R72 before walking away toward the serving line. R72 picked up a piece of bread form the tray, and held it in her hand, and stated, Oh bread; do I have any butter? while turning to her left and right. The resident seated next to her replied, You do not, but I have some and handed butter to R72. CNA I was approached as they crossed the dining room and was asked for R72's meal ticket. When this surveyor reapproached R72's table, R72 asked several times, What am I eating? I cannot see, can someone tell me what I have?. No staff were observed identifying the resident's food items on her plate. A review of R72's lunch ticket (#349) showed the alert Blind- describe meal to resident., which was highlighted in yellow. A review of section GG in R72's Minimum Data Set (MDS) assessment revealed a functional status, Eating; code 05. Indicating Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. A review of R72's care plan revealed: Focus: Alteration in nutritional status related to weakness and debility . Guest at risk for weight changes related to fluid status shifts, edema, and diuretic therapy prefers to eat with her hands & wears her own clothing protector; Date Initiated: 09/04/2025 with an Intervention: Provide diet per physician order; Regular diet, regular texture, thin liquids, low sodium/DM (diabetes) modified, guest blind- describe meal to guest; Date Initiated: 08/26/2025 Revision on: 08/29/2025. A review of R72's Kardex (resident care guide) revealed: Eating and Nutrition: Provide diet per physician order; Regular diet, regular texture, thin liquids low sodium/DM modified; guest blind-describe meal to guest. According to a review of R98's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to a displaced fracture of the left femur, orthopedic after care and diabetes mellitis type 2. A review of R98's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Additional medical diagnosis included depression, dementia and hypertension. On 09/23/2025 at 11:43 AM, R98 was observed in his room lying in bed watching tv and agreed to an interview regarding his care at the facility. R98 said that he had waited up to 30 minutes on multiple occasions for his call light to be answered, which he expressed was concerning to him because he had experienced 3-4 sugar drops since he has been here, (which indicated a drop in blood glucose). R 98 further said that late one night a nurse came in and handed him a bunch of pills, including a small blue pill, which he had never taken before. When R98 asked the nurse about the pill, the resident reported that the nurse responded, I am not here to tell you what it is, I am here to make sure you take it. R98 said that upset him, because I did not know what it was. R98 said he was hesitant to take it without being informed and asked, don't I have a right to know? Staff did not respond to resident's (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	getting her cleaned up. She stated, It was absolutely humiliating and I have never been through anything like that, and I am (stated age) old. Staff did not respond to resident's needs in a timely manner, leading to resident reported humiliation. On 09/24/2025 at 1:14 PM, during an interview with R143 she reported that yesterday (09/23/2025) she had to wait over a half hour for staff to respond to the call light. She stated, I don't typically turn on my light if I don't need something and I understand it takes time; but that's a little too long without any communication to me about what's going on. A record review of R143's care plan revealed: Focus: Risk for falls r/t weakness and debility . with Interventions: .Bed mobility: 1PA; Immobilizer to LLE (left lower extremity); Reinforce need to call for assistance; Transfer status: 2PA with slide board; Ambulation status: non-ambulatory. Focus: Actual ADL/Mobility deficit r/t weakness and debility. with Interventions: Assist the pt (patient) with showers/bed baths; Assist with dressing, hygiene and toilet needs; Explain all procedures. On 09/24/2025 at 2:20 PM, during an interview with a confidential group of residents it was revealed, a consensus that call light response was long, reported averages of half an hour or longer on the weekends, citing there was often just one CNA per hallway and indicated not enough staff to answer call lights timely and assist with resident needs. The group expressed concern with They (the staff) will come in shut the light off and not help you or return. and the wait being up to 45 minutes. On 09/25/2025 at 10:00 AM, during an interview with Nurse J about call lights and how staff got alerted since there was no light or sounds in the hallways, she said they used a pager system. She was asked if she had a pager, and she said she had no pager and that only the CNA's carried pagers, and nurses did not. When asked if nurses answered call lights, she stated If I am aware of them I will, but I do not get a pager. On 09/25/2025 at 3:20 PM, during an interview with Kitchen Manager A and Culinary Specialist B it was said the staff serves the dining room first then the residents dining in their rooms. The staff should be checking the meal tickets for residents as a final check of accuracy and needs. According to a record review of the facility's Quality of life – dignity policy statement, Each resident shall be cared for in a manner that promotes and enhances quality of life dignity and respect and individuality. Listed under Interpretation and Implementation, was written: 1 Residents shall be treated with dignity and respect at all times. 2 Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 7 Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis or care needs. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was his fiancé. She was asked about the resident's call light as it was again observed hanging on the wall and not in reach of the resident. She said she had asked him not to have it because he didn't know what to do with it and in the past and had tangled it on himself. She said if he had the call light, he would just push the button and not know why. The resident's fiancé was asked how he could call for help, and she stated, He can't. There was no alternative method for calling for assistance in the room and there was a sign on the wall to keep the door closed. A record review of the Care Plans identified the following: Actual ADL (activities of daily living)/Mobility deficit related to CVA (stroke), head injury, skull/orbital fracture, diabetes, anemia, seizures, Gout, dysphagia, Dyslexia, history of MI (heart attack), hypertension, muscle weakness and debility, date initiated 7/28/2023 and revised 7/3/2024 with Interventions including: Family prefers for call light not to be within reach, dated initiated 9/23/2025; Frequent checks related to family not wanting call light within reach, date initiated 9/23/2025; Guest prefers to have door closed at all times with note on door, date initiated 7/17/2024. There was no identified alternative to the call light for Resident #76. With his door closed it would be difficult to know if he needed help. A review of the progress notes for Resident #76 revealed a note dated 3/5/2025 at 12:47 PM, Guest fiancé requesting to not give guest call light because he just plays with it. Fiancé educated on the importance of having call light within reach, she verbalized understanding fidget [NAME] given to guests to assist with the need to move fingers. On 9/25/2025 at 3:40 PM, during an interview with the Administrator, she said the resident's fiancé had requested for the resident not to have a call light and in the past, they had tried a Fidget [NAME] at the fiancé's request but it didn't work. When asked if other alternative methods of requesting help had been attempted, the Administrator said the staff perform frequent rounding. When asked how often that was, she said there was no specific timeframe. A review of the Kardex for Resident #76 revealed the following: Safety: Reinforce need to call for assistance; Family prefers for call light to not be within reach; Frequent checks related to family not wanting call light within reach: bell at bedside. There was no bell observed at the bedside. A review of the physician orders did not identify any alternate means of communicating need for assistance for Resident #76.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident received necessary care and services to maintain the highest practicable level of health by not providing timely IV (intravenous) antibiotic therapy or alternative treatment during a peripherally inserted central catheter (PICC) line occlusion, for one resident (R24) of 2 residents reviewed for IV therapy, resulting in R24 missing five consecutive doses of prescribed IV antibiotic vancomycin (an antimicrobial medication used to treat resistant bacteria) over two days, placing the resident at risk for a delay in resolution of infection and increased risk for further antibiotic resistance and clinical decline.Resident #24 (R24):According to a review of R24's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to diabetic ketoacidosis (DKA) (a buildup of ketones in the blood caused by elevated blood sugar making the blood acidic), weakness and IV Vancomycin infusion (42 days remaining on IV). R24's Minimum Data Set (MDS) record revealed Brief Interview of Mental Status (BIMS) score of 12/15 indicated the resident had moderately impaired cognition. Medical diagnosis included: Sepsis (the bodies extreme response to infection), Methicillin Resistant Staphylococcus Aureus (MRSA) infection (bacteria that is resistant to many antibiotics, including methicillin), diabetes mellitis type 2, calculus of kidney (kidney stones), Heart failure, acute and sub-acute infective endocarditis (inflammation of the hearts lining).On 09/23/2025 at 1:23 PM, an observation was made outside R24's room, to the left of the door on the wall was a pink butterfly note that indicated R24 had enhanced barrier precautions (EBP) (gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multidrug resistant organism/MDRO). R24 was sitting in his wheelchair in his room, agreed to an interview regarding his care at the facility. During the interview he reveals that he went 3 1/2 days without getting his IV antibiotics and when he was asked why that happened, he replied, My IV line was clogged and apparently no one here was qualified to fix it he continued with It took them 2-3 days to get someone out here who could fix it. R24 said missing the IV antibiotics for that long was concerning to him because he Just wanted to get stronger so I can return home. He was glad that it was finally taken care of but wondered why it took so long. A record review of R24 medical records revealed the following under progress notes: 9/20/2025 (at) 06:04 Skilled Charting: . PICC line dressing was change and circumference was measured. 9/20/2025 (at)16:51 Medication Administration Note: Vancomycin HCl Intravenous Solution 1000 MG/200ML Use 1 gram intravenously two times a day for infection until 10/04/2025. Held r/t awaiting picc line flush/replacement at this time. 9/20/2025 (at) 21:14 Medication Administration Note: Vancomycin HCl Intravenous Solution 1000 MG/200ML Use1 gram intravenously two times a day for infection. Unable to flush to PICC line. Waiting on (the contracted mobile medical) to de-clot/replace RUE PICC line. Physician notified. 9/21/2025 (at) 06:45 Skilled Charting . Guest has a clogged PICC line, (the contracted mobile medical) was scheduled to come out and declog, (the contracted mobile medical) did not make an arrival. Physician was notified of (the contracted mobile medical) not arriving to the facility. c/o pain and asked for prn pain medication. Staff did not receive an order for or initiate an alternative access site to administer IV Vancomycin that was on hand at facility, following a delay in PICC line access. 9/21/2025 (at) 12:24 Medication Administration Note: (the contracted mobile medical) representative stated they will not be willing to come out until Cathflo (used to restore function of catheter lines) medication is on hand in facility. Medication was ordered via provider, pharmacy was contacted and notified, pharmacist stated it will be here this evening. 9/21/2025 (at) 15:49 Skilled Charting: Yesterday (9/20/25) morning, nurse noted that picc line was difficult to flush, and unable to run gravity Vanco drip effectively. On-call provider was notified and ordered (the contracted mobile medical) to try to de-clot or replace picc line. (the contracted mobile medical) was contacted that morning for de-clotting/picc replacement, and order was entered. Provider ordered hold for Vanco morning dose. (the contracted (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mobile medical) nurse . contacted facility and stated that she would not be willing to visit facility until additional measures such as another flush attempt, filter attachment removal, or use of Cathflo was attempted by facility nurse first. Provider was made aware, cathflo was not available in backup, so heparin dwell flush was ordered by provider. It was unsuccessful. Filter attachment was removed, and another saline flush was attempted, and it was still unsuccessful. Provider was notified, and (the contracted mobile medical) was notified. Representative stated the previous replacement order was not cancelled, and that it was labeled as 'dispatched', and that a nurse should be there that afternoon or evening. (the contracted mobile medical) nurse. contacted facility this morning 9/21/25, stating she never received a call back and asked about status of picc line. Facility nurse stated that they were unaware of the need for a return call. measures she requested were not successful. Nurse . stated that she would be unwilling to visit facility until Cathflo medication was on hand in facility, and needed to be ordered from out pharmacy. She provided the following contact. notify her when the pharmacy order was confirmed. Provider was notified.order was entered. Pharmacy was contacted, and stated the Cathflo medication should be delivered this evening alongside regular pharmacy delivery. Pharmacy was also notified of 3 total missed Vancomycin IV doses due to inaccessible picc, and they states they would note that down. (the contracted mobile medical) nurse.was contacted at the provided number, and notified of (pharmacy) order confirmation. (contracted nurse) requested to be contacted at the same phone number to be noticed of when medication arrives. Provider and management aware of situation. 9/21/2025 (at) 23:25 Medication Administration Note: Guest picc line not working, been waiting for cathflow to arrive now it arrived (the contracted mobile medical) nurse. stated that she cannot come out and the morning nurse would have to come out. 9/22/2025 (at) 00:35 Skilled Charting: . Guest picc line is clogged and (the contracted mobile medical) nurse was waiting for cathflo to arrive from pharmacy. (the contracted mobile medical) Nurse. was called and she stated that she can not come out because she is off work and the morning (the contracted mobile medical) nurse comes on shift about 9am and she will be here to fix picc line. On call provider aware with no new orders, continued with Picc line was flushed but it was hard to do. 9/22/2025 (at) 09:48 Skilled Charting: This writer was informed that guests PICC Line had been difficult to flush and antibiotics not given for 2 days, 4 doses. Discussed with NP, gave verbal order to extend antibiotic treatment two days. 9/22/2025 (at) 12:45 Skilled Charting: Discussed worsening BLE edema since Wednesday, now 3+ up to knees. Per NP change lasix (diuretic medication) order. Aware (the contracted mobile medical) here for PICC troubleshooting at this time. 9/22/2025 (at) 14:36 Skilled Charting: Spoke to guest and significant other to touch base and address any concerns or complaints that they may have. Guest stated his only concerns was his picc. According to a record review of R24's orders revealed the following: Dated 09/22/2025 Vancomycin HCl Intravenous Solution 1000MG/200ML (Vancomycin HCl) Use 1 gram intravenously two times a day for infection until 10/06/2025. According to R24's medication administration record (MAR), the Vancomycin IV order was scheduled as upon and HS-Li (hour of sleep/liberal), as clarified by staff Interview Nurse G who reported the at liberal times are medication orders that are scheduled to be given anytime between 07:00 AM-10:00 AM & 18:00 PM-21:00 PM (06:00 PM - 09:00 PM). This was confirmed by the time frame listed in the scheduled medications administration time.According to a review of Food and Drug administration (FDA) Vancomycin prescribing information/FDA label related that, the usual daily dose IV dosage of Vancomycin injection is 2 grams divided either as 500mg every 6 hours or 1 gram every 12 hours. A record review of R24's medical administration records (MAR) revealed the following: Vancomycin HCl Intravenous Solution 1000 MG/200ML (Vancomycin HCl) Use 1 gram intravenously two times a day for infection.The following dates for the Upon (at liberal time 07:00 AM - 10:00 AM) dose not given are noted as: 09/20/2025; 09/21/2025; 09/22/2025The HS dose (at liberal time 06:00 PM - 09:00 PM) not given are noted as: 09/20/2025; 09/21/2025A total of 5 consecutive doses of Vancomycin were not given.Each missing dose was reason noted as being 5 and 9 (5 being= to hold/see nurses notes and 9 being = to other/see nurses notes) per key on MAR. On 09/24/2025 at 1:38 PM, R24 was observed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sitting in his wheelchair in his room, the PICC line dressing film on his right upper arm was dated 09/22/2025. The resident confirmed that 09/22/2025 was the date on the dressing and he stated, That is the day the special nurse came out to fix my IV; she changed it. R24 reported that he was supposed to get his IV antibiotics two times a day. He confirmed that he had received his morning dose on the day of the survey (09/24/2025).On 09/25/2025 at 8:16 AM, an observation of R24 sitting in his bed identified he had just completed his breakfast and ate about 75%. When asked, he reported he had not received his morning dose of IV antibiotic yet and stated, They bring it when they bring it, it's never at the same time. On 09/25/2025 at 8:35 AM, during an interview with Nurse G it was revealed that R24 had not yet received his morning dose of IV Antibiotics. Nurse G was asked when it would be administered and she stated, It's an at liberal time, asked nurse G what that meant and she replied, It can be given between 7-10 in the morning., It was further discovered the night dose was scheduled as at liberal also with a window administration time of 1800-2100 (which is 6:00 PM-9:00 PM). When asked if that was normally scheduling for an antibiotic such as Vancomycin, Nurse G replied, It is a twice a day medication; that is how it was scheduled.On 09/25/2025 at 4:04PM, an interview with Nurse G about R24's PICC line revealed that she was working for several shifts when the IV antibiotics were unable to be administered. Nurse G was asked about it and she stated, I was working with the resident over the weekend, I was unable to flush or run the Vancomycin because the PICC line was clotted. She said she let the provider know she had to hold the medication and that they ordered for (the contracted mobile company) to come in to assess and de-clot or replace the line. Nurse G cited several delays that happened and summarized the following: Prior to coming to the facility, the contracted vascular access nurse said she requested measures that were necessary to be taken on the part of the facility nurses (1) attempt to flush the PICC line (2) Change the filter (3) attempt to dwell/flush with Cathflo (a medication used to restore function of catheter lines).The facility did not have Cathflo on hand.There was a delay in the pharmacy delivery of Cathflo for an undetermined reason; An unwillingness for the contracted nurse to come in without the medication available at the facility; and a delay from the contracted company.Nurse G reported that the issue was not resolved until sometime on Monday (09/22/2025). When asked how many doses of the IV vancomycin the resident missed because of all of this she replied, 2 days so, 4 doses at least. On 09/26/2025 at 12:52PM to ~1:12PM during an interview with Corporate Clinical Nurse F, he was asked about the order correspondence and consultation notes form the contracted mobile company that came out for R24's PICC line. He stated, they did not complete the order and on that Monday morning one of the nurses that was previously an ICU nurse fixed the PICC line. When Corporate clinical nurse F was asked what the staff nurse did to fix the PICC and he stated, They just have the skills, they know tricks they are from the ICU. Corporate clinical nurse F was asked if all the nurses working with PICC lines should have the necessary skills to care for them and he stated, Yes, they should. He then exited and came back later and said that the former ICU did not fix the PICC and it was done by (the contracted company). A record review of R24's medical records revealed the following (mobile contracted company) documentation labeled: Peripheral intravenous catheter insertion CVC care/ Maintenance document dated 09/22/2025 had a noted arrival time at 09:50 AM with departure time of 11:10 AM. The note section on the document revealed: .Dressing (medical symbol used) change done. line discovered to be kinked under Biopatch (type of medical cover/dressing) . length consistent with baseline, has not been dislodged and continued Line redressed, ?(unkinked line)' line, now flushes with ease but sluggish blood return. Instilled 2 mg Cathflo. after dwell the line with brisk blood return. According to a record review of the facilities nursing skills and competencies assessment for Nurse G, in the IV Therapy section: Date (signed off on as competent in skill) 8/13/2025; Competence indicator (skill competent to perform): IV insertion, IV administration, IV documentation, IV dressing change.There was no documentation on PICC line care, maintenance or assessment listed in competencies. According to a review of the facilities Infusion maintenance table, reads: under site maintenance for PICC section titled, transparent dressing change, PICC listed 24 hours post insertion, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then Q week (every week) and as needed (PRN) - measure upper arm, circumference and external length catheter. According to a record review of the (Mobile contracted company) Standard terms and conditions contract: Under services it read, For vascular access services, Provider shall provide registered nurses (RN's) qualified in infusion therapy administration that administer placement of vascular access devices and follow up nursing care if required. The nurse's responsibility at the location is as follows (1) assessment of the patient's pick or midline PIV line insertion (2) inform consent for pick or midline procedure (3) verification of physician's order number (4) ultrasound guidance for PC insertion; and (5) documentation related to insertion.Section 1.2.2 non-stat (non-urgent) imaging exams, read, Every effort will be made to complete services within the day of when services are ordered. In the event the provider is unable to complete services within a day of when services are ordered, customer will be notified in the exam will be performed as scheduled.Section 1.3 special services / on-call emergency provider services read, If requested by customer and where available, provider shall be available 24 hours a day, seven (7) days a week for stat emergency requests. According to a record review of R24's lab results, the following Vancomycin Trough levels were included in the resident's chart: 09/22/2025 collected at 03:40 AM: (test) VANCOMYCIN, TROUGH (result) 6.6 (units) ug/mL (Reference range) 10.00-20.00 (flag) L (low). 09/17/2025 collected at 05:50 AM: (test) VANCOMYCIN, TROUGH (result) 16.5 (units) ug/mL (Reference range) 10.00-20.00. 09/10/2025 collected at 13:45 PM (01:45 PM) : (test) VANCOMYCIN, TROUGH (result) 10.6 (units) ug/mL (Reference range) 10.00-20.00.According to a review of Food and Drug administration (FDA) Vancomycin prescribing information/FDA label related that, the usual daily dose IV dosage of Vancomycin injection is 2 grams divided either as 500mg every 6 hours or 1 gram every 12 hours. According to the Infectious Disease Society of America (IDSA) Vancomycin guidelines 2020 Update, The guidelines recommend an AUC/MIC (Area Under Curve/Minimum Inhibitory Concentration) ratio (parameter to assess effectiveness of an antibiotic) of 400-600 mg*hour/L to achieve clinical efficacy and ensure safety for patients being treated for serious methicillin-resistant Staphylococcus aureus infections and according to the IDSA clinical practice guideline recommendation achieving a trough (parameter to assess effectiveness of an antibiotic) concentration of 15-20 mg/L (milligram per liter) for complicated infections. These guidelines emphasize the importance of consistent and timely administration of vancomycin to maintain therapeutic exposure and endorsed Interruptions in therapy can lead to suboptimal drug exposure and potential therapeutic failure. According to the Centers for Disease Control and Prevention (CDC), Healthcare Infection Control Practices Advisory Committee (HICPAC) guidelines, they said delays in the administration of critical antibiotics, such as vancomycin, can compromise treatment efficacy and patient outcomes.A review of Infusion Nurses Society (INS) standards of practice (2021), concluded that when the access or functionality of a vascular access device (VAD) site was compromised, healthcare providers must have acted promptly to ensure the continuation of necessary treatments, this included the use of alternative venous access routes or the administration of medications via different modalities to prevent critical treatment interruptions.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure completion of yearly Performance reviews and competencies for 6 of 6 Certified Nursing Assistants reviewed for yearly education, resulting in the potential for the nurse aides to not be able to safely provide the needed care and services for the residents.Facility Sufficient and Competent Nurse Staffing On 9/24/2025 at 2:30 PM, during an interview with Staff Education Nurse M she said the nurses and nurse aides had a 2-day classroom orientation where they completed online computer training and then they were assigned to a preceptor on the nursing units and were to complete competencies. Nurse M was asked if the staff completed hands on competencies and she said she went over Personal Protection Equipment/PPE's and Hand Hygiene with them.On 9/24/2025 at 3:00 PM, Human Resources/HR Manager X was asked for education files for Certified Nursing Assistants/Nurse Aide N, O, P, Q, R, S. A record review of the education files for Certified Nursing Assistants N, O, P, Q, R, S revealed the CENA Orientation & Annual Competency Checklist had 74 competency check off items listed. Each Nurse aide placed their initials next to the boxes they completed, and each one said they completed all of the items in one day. The Nurse Aide signed that they completed all the items in one day and the Staff Educator M signed that they were completed on the same day. Some of the check off competencies did not have an initial next to it, but a line was drawn through the item for almost 100% of the items.On further review of the Nurse Aide competencies the following was identified: Nurse Aide O had a straight line dragged through all competency entries and the form was signed as completed on 11/19/2024 by Nurse Aide O and Nurse Y. Nurse Aide P did not have a last page to the competency. There was no identified completion date.Nurse Aide R had a straight line dragged through all of the competency entries. The competency was signed as completed by Nurse Aide R and Nurse Y on 1/28/2025.There were no entries for PPE or Hand Hygiene on the CENA Orientation & Annual Competency Checklist and there was no document confirming an in-person hands on competency for each had been completed.On 9/25/2025 at 11:28 AM, Assistant Director of Nursing AA was interviewed about nurse and nurse aide orientation. She said it started with a 2-day computer training and then they would be assigned to the floor to complete competencies. On 9/25/2025 at 11:40 AM, the Administrator and Corporate Nurse E were interviewed related to the Certified Nursing Assistants checking themselves off on their competencies. The Competency forms were reviewed for Nurse Aides N, O, P, Q, R and S. They Nurse Aides initialed they completed the competencies and then signed and dated it was done. There were no specific dates when each item was completed; only when the entire competency was completed and then the Staff Education Nurse signed the form. There was an entry for Preceptor CENA Signature, but 3 out of 6 were blank, one said NA, and one had no signature page. It was unclear who was observing the Nurse Aides to ensure they completed each competency appropriately. The Administrator and Corporate Nurse E were asked to review the yearly Performance evaluation for each nurse aid (N, O, P, Q, R, S) and they said they did not do that. They said they had the yearly competency check offs. The Administrator and Corporate Nurse E were asked how they determined which areas of improvement were needed for the Nurse aides if there was no evaluation and they said they no longer did that. On 9/26/2025 at 9:30 AM, the Director of Nursing said there was no staffing policy. A review of the Facility Assessment dated revised 7/1/2025 by the Administrator identified the following: Purpose: The Facility assessment is a complete review of internal human and physical resources required by the facility to care for residents competently during day to day and emergency operations. There are three components to the review: 1. Resident profile. 2. Services and care offered. 3. Facility resources needed to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, education and training. Nursing Services: The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A facility must develop, implement, (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and maintain an effective training program for all new and existing staff. Required in-service training for nurse aides: In-service training must- address areas of weakness as determined in nurse aides performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff. Training, Competencies: As needed and monthly and annually using Health care academy (online training).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings include:Resident interview On 9/24/25 at 10:10 AM, an interview was conducted with a Confidential Resident II regarding issues with their care at the facility. The Resident answered questions and engaged in conversation. The Resident expressed a concern that she had witnessed while eating. The Resident reported that a Resident that she ate meals with was eating lunch and had most of her meal eaten with a spoon. The Resident reported that she had two spoons stuck together and the spoons were dirty that was stuck to the other spoon. The Resident reported being upset that the spoons had been wrapped in a napkin by staff and that the spoons had not been detected as being dirty and stated, you could get sick from that. On 09/23/2025 between 9:00AM - 9:30AM during the initial kitchen tour with the culinary Specialist B and the Kitchen Manager A, observed dessert plates stored upwards so that the interior was exposed with one of the bowls visibly soiled with a yellow liquid substance, located in the clean dish area. When interviewed on whether these dishes were supposed to be clean, the Culinary Specialist B confirmed these were clean dishes and proceeded to take the soiled dish back to the dishwashing area. On 09/23/2025 at 12:40 PM during lunch service, meatballs were temped using Thermapen at 130 and then 122 degrees Fahrenheit on two separate meatballs held on the steam table located in the northside kitchen. When interviewed, the Kitchen Manager A stated they try to keep the hot holding temperature at 135 degrees Fahrenheit. According to the 2022 Food Code, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, Cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: in a clean, dry location; where they are not exposed to splash, dust, or other contamination; and at least 15 cm (6 inches) above the floor. and Clean equipment and utensils shall be stored: in a self-draining position that allows air drying; and covered or inverted. 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, All hot foods must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit . hot food items may not fall below 135 degrees Fahrenheit after cooking, unless it is an item which is to be rapidly cooled to below 41 degrees Fahrenheit and reheated to at least 165 degrees Fahrenheit prior to serving.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly dispose of waste and maintain the dumpster area to mitigate the presence of insects and rodents, potentially affecting all residents, staff, and visitors in the facility.Findings include:On 09/24/2025 at 8:50AM - 9:46 AM during the environmental tour with the Maintenance Director C, observed a strong odor in the dumpster area and plastic lids, plastic cups, a chip bag, and dark residue surrounding the area behind the dumpster. When interviewed, the Maintenance Director C stated that they do rounds every so often.According to the 2022 Food Code, 5-501.115 Maintaining Refuse Areas and Enclosures A storage area and enclosure for refuse, recyclables, or returnable items shall be maintained free of unnecessary items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) Properly store clean linen, sanitary supplies and Personal Protective Equipment (PPE), 2) Ensure distilled water for respiratory care was replaced properly for Residents #8, 3) Ensure appropriately associated precaution signage was posted, 4) Use/disposal of PPE was provided and consistent for Residents #24 (R24) and #153 (R153), and 5) Failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing, resulting in an increased potential for contamination and a possible decrease in the satisfaction of living, affecting residents in following areas: 800, 600, and 100 hallways. Findings include: Resident 24 (R24) According to a review of R24's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to diabetic ketoacidosis (DKA) (a buildup of ketones in the blood caused by elevated blood sugar making the blood acidic), weakness and IV Vancomycin infusion (42 days remaining on IV). R24's Minimum Data Set (MDS) record revealed Brief Interview of Mental Status (BIMS) score of 12/15 that indicated the resident had moderately impaired cognition. Medical diagnosis included: Sepsis (the bodies extreme response to infection), Methicillin Resistant Staphylococcus Aureus (MRSA) infection (bacteria that is resistant to many antibiotics, including methicillin), diabetes mellitis type 2, calculus of kidney (kidney stones), Heart failure, acute and sub-acute infective endocarditis (inflammation of the hearts lining). On 09/23/2025 at 1:23 PM, an observation was made outside R24's room, to the left of the door on the wall was a pink butterfly note that indicated R24 had enhanced barrier precautions (EBP) (gown and glove use during high-contact resident care activities) R24 was sitting in his wheelchair in his room, agreed to an interview regarding his care at the facility. R24 explained, he was here for rehabilitation and that he was also receiving IV antibiotics for an infection, his goal was to get stronger so I can return home. When R24 was queried about the EBP status and when he was being provided care, he said they always wear gloves, rarely a gown and could not recall ever seeing a mask used during his care. On 09/24/2025 at 1:38 PM, R24 was observed sitting in his wheelchair in his room, the PICC line dressing film on his right upper arm was dated 09/22/2025. During an interview, R24 remarked, they (staff) are wearing gloves and gowns more today, are they supposed wear them (gowns) all the time? They normally just wear gloves. On 09/25/2025 at 8:15 AM, An observation of R24's door was made and there was a contact precaution (requires PPE of gloves and gown, to minimize transmission of infectious organisms through direct or indirect contact with a person or their environment) sign on the residents door, the EBP sign was located on the wall to the left of the door with a plastic drawer cart containing PPE (personal protective equipment) under it, and a wooden slatted hamper to the right of the door that had yellow gowns in it. The Director of Nursing (DON) was on the hall and was asked about the contact precautions sign, she replied it has always been there, he has been in contact since he has been here. On 09/25/2025 at 8:16 AM, R24 was observed sitting on his bed and identified he had just completed his breakfast. While verifying with R24 staff's use of PPE, he was asked if they wore gowns when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entering and before when performing care, he said just yesterday and today. R 24 confirmed it was not a consistent practice prior to that. On 09/25/2025 at ~(approximately) 8:20 AM, upon exiting R24's room, gown was disposed into the wooden slatted hamper that was observed in the hall by R24's door. Nurse L said the hamper was for clean gowns. She confirmed there was no sign to identify if the gowns were clean or dirty. According to a review of the CDC recommendations for contact precautions: Everyone must: clean their hands, including before in entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. #2 put on gown before entering room. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. #3 use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. A review of R24's Kardex (resident care guide) revealed: Resident care: .enhanced barrier precautions as directed. This includes gowns and gloves for high-contact resident care activities. A review of R24's physician orders revealed: Start date: 08/22/2025; Enhanced Barrier Precautions as directed. This includes gowns and gloves for high-contact resident care activities. Specify why: PICC Line and wounds. Start date: 08/22/2025; Contact Precautions: Gown and Gloves. Start date: 09/19/2025; Wound Care: Cleanse stage 2 pressure injury to sacrum. Resident 153 (R153) According to a review of R153's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to vascular surgery, stomach ulcers, gastritis and feeding tube placed on 09/11/2025. R153's Minimum Data Set (MDS) record revealed Brief Interview of Mental Status (BIMS) score of 06/15 indicated the resident had severely impaired cognition. Medical diagnoses included dysphasia (moderate language impairment), diabetes mellitis type 2 and debility. On 09/23/2025 at 11:15 AM, an observation was made outside R153's room, to the right of the door on the wall was a pink butterfly note that indicated R153 had enhanced barrier precautions (EBP). When attempted to meet resident, It was reported by staff that R153 and his family were having a care conference. On 09/24/2025 at 8:44 AM, an observation was made outside R153's room, to the right of the door on the wall was a pink butterfly note that indicated R153 had enhanced barrier precautions (EBP), no PPE cart or bin present at room. R153 is resting in bed with tube feed up and running. He said he has not been here long; he was unable to give details about his reason for being here, but confirmed he attends therapy. There is a garbage can bin labeled dirty gowns inside R153, no trash nearby. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/25/2025 at 8:35AM, an observation was made outside R153's room, to the right of the door on the wall was a pink butterfly note that indicated R153 had enhanced barrier precautions (EBP), no PPE cart or bin present at room. CNA K that provides care for R153 was asked, where she would obtain PPE to provide R153's care and she looked around then stated, I would have to go down the hallway to see if I could find it. CNA K was asked if she could identify a PPE bin near R153's room and she stated, No, there should be one outside the room, CNA K confirmed that there was none present outside R153's door. On 09/25/2025 at 12:10 PM, an observation was made of Nurse J, she pulled out a gown from the clean bin and attempted to untie a knot that was in the neck ties, she was unable to get then un-knotted. She stated, I don't think I am going to get that out. Nurse J rolled the knotted gown into a ball and placed it back into the clean bin and grabbed another clean gown out and put it on. Nurse J entered R153's room to take down R153's tube feeding and change the dressing, she discovered it still needed to run, and said to come back in about 30-40 minutes. On 09/25/2025 at 1:05PM, an observed was made of Nurse J donned a gown, enter the room, and prepare to take down R153's tube feeding and change the PEG tube (surgically placed tube placed for nutrition) dressing. Nurse J did not close the resident's door prior to starting care, when her attention was called to it, she stated, Oh sorry, I should have done that. Nurse J changed the dressing and discovered she did not have a pen to date the dressing; she left the room and observed her lift the clean gown bin and place the gown in the bin and then grab it back out and place it in the dirty bin inside the resident's room. She put on a new gown and returned inside the room, she dated the residents dressing and then reached under her gown to her clothes and placed the pen in her pants pocket. A record review of R153's orders revealed: Enhanced Barrier Precautions as directed. This includes gowns and gloves for high-contact resident care activities. Specify why: Peg tube (feeding tube) A record review of R153's care plan revealed: Focus: Actual ADL/Mobility deficit; interventions: Assist the pt with showers/bed baths; Assist with dressing, hygiene and toilet needs; ROM with care daily. Focus: Alteration in nutritional status related to Enteral/parenteral nutrition (via Peg tube) , Recent hospitalization, Swallowing difficulty.; Interventions: . There was no documentation on of residents enhanced barrier precautions in the care plan. A review of the facilities Enhanced Barrier Precaution - Policy – Policy – Procedures revealed: Enhanced Barrier Precautions: Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Key points included: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a review of the CDC recommendations for enhanced barrier precautions: Everyone must: clean their hands, including before in entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs as assisting with toileting; device care or use: central line, urinary catheter, feeding tube, tracheostomy; Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. Resident 8 (R8): A review of Resident 8's medical record revealed an admission on [DATE] and readmission on [DATE] with diagnoses that included heart failure, dementia, chronic obstructive pulmonary disease (COPD) with exacerbation, acute respiratory failure with hypercapnia and hypoxia and obstructive sleep apnea. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 5/15 that indicated severely impaired cognition. Further review of the medical record revealed the Resident had a Bi-PAP (bilevel positive airway pressure-a device that helps with breathing by supplying pressurized air through a mask or nasal plugs often used for patients who have difficulty breathing due to conditions such as sleep apnea, COPD or respiratory failure) machine. Review of Resident 8's orders revealed order dated 8/19/24, Nurse to sanitize BiPap machine. Nurse to sanitize BiPap machine in the morning every Thu (Thursday). On 9/23/25 at 11:57 AM, an observation was made in Resident 8's room of a Bi-Pap machine. The humidification chamber was filled with water. At the bedside was a gallon container of distilled water. The gallon container of distilled water had a small amount of water left. The handwritten date on the gallon read 3/29. On 9/25/25 at 12:50 PM, an observation was made in Resident 8's room. Staff were assisting the Resident to eat while he was in bed. An observation was made of the opened gallon container of distilled water with the handwritten date of 3/29. On 9/25/25 at 11:59 AM, an interview was conducted with the Assistant Director of Nursing (ADON) AA regarding the distilled water for C-PAP and Bi-PAP machines. The ADON was asked how long the distilled water was good for once opened. The ADON indicated they should be changing it out every week. An observation was made of Resident 8's distilled water with the date 3/29. The ADON indicated the date would be the open date of when the distilled water was opened, the date would be written on the container. The Nurse reported that the water was outdated and needed to be replaced. Resident 131: An observation of Resident 131's room with the ADON revealed an opened container of distilled water that was not dated. The ADON indicated it should be dated when opened and emptied the remaining water and disposed of the container. A review of the facility policy for C-PAP/Bi-PAP machines was requested but did not give guidance on use and storage of the distilled water to maintain good infection control standards or condition over time once opened to prevent contamination of infectious organisms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility: The laundry room observation was conducted with the facility's infection control nurse (ICP Nurse M) and corporate infection control nurses (Corporate ICP HH') on September 25, 2025, at 12:00 PM. The laundry staff were unavailable in the soiled linen room and the wash & dry rooms at the beginning of the observation. Later, two laundry staff members were found in the clean linen room. The two laundry staff indicated they were there preparing and folding clothes and linen, but no clothes or linen were found nearby. On September 25, 2025, at 12:05 PM, it was observed that one of the three dryer machines, #3, was in use and actively in a drying cycle. Two dryers (Dryer #1 and Dryer #2) were not in use, and the machine was cool to the touch. The surveyor asked the laundry personnel, FF, to open the dryer lint door for dryers #1 and #2. Both dryers (#1 and #2) were observed to have an obvious visible accumulation of fibers, fuzz, and fluff on the lint trap after use, which had not been cleaned of debris. Accumulated debris was found on both the lint screen and its surrounding area. When Laundry staff FF was asked about the protocol, the laundry staff FF stated they were supposed to clean the lint trap and clear the surrounding area after every load but did not get to it. On 9/25/25 at 12:05 PM, the laundry staff member FF was asked to describe the process of washing the non-disposable yellow gowns staff use for PPE. Laundry staff member FF revealed that the process involves placing the washed and dried yellow gowns directly into the transport carts and delivering them to the Personal Protective Equipment (PPE) bin/ in each unit. Laundry staff FF specifically described that they don't fold the yellow gowns individually. From the dryer, they drop them into the blue transport cart and deliver them to the units. Laundry staff FF was explaining the process to the surveyor while next to the blue transport cart. The Laundry staff member FF uncovered the blue transport bin and noticed that the contents included personal clothing, trash, and empty trash bags. Laundry staff member FF indicated that there shouldn't be items there and was unsure if the items found were clean or dirty. She was uncertain how often they are washed, cleaned, or sanitized, and who is responsible for cleaning the bins before clean clothes and linens are put in. The Laundry Staff FF was asked if they use the same carts that handle the dirty soiled linen and transport clean linens, clothes, and PPE gowns as well? Laundry Staff FF had no answer. When three laundry staff members in the clean linen room were asked who washes and how often they disinfect the blue bins that transport the soiled and clean laundry. They did not answer. One of the staff members said, once a day, but when asked who is responsible or how they get assigned to wash them, they did not answer. When asked what the process is for washing the bins? Sprayed with bleach water? Soap and water? Or wipe down with a disinfectant. How do they dry the bins? No one can answer., A policy for Lint Trap Maintenance and Cleaning of Laundry transport bins was requested from the ICP Nurse. No policies were received for review. However, an in-service education on 9/25/25, following the above observations, was conducted for the four laundry staff members. Topic: Must remove all garbage from soiled linens before washing—clean Linen Carts and dry lint trap cleaning responsibilities. There was no policy received as requested related to Cleaning/Maintenance scheduled on Dryer Lint traps. However, the Lint Trap Cleaning Log Form with a revised date 8/19/2025, noted in the form as a reminder: Lint Traps are to be cleaned after every use. On September 25, 2025, at 12:43 PM, the Director of Nursing (DON) was informed of the observation. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that bathroom doors and blinds in residents' rooms were in good working order for two residents (61 and 128) of four residents reviewed for a clean, comfortable, homelike environment.Findings include:Resident #61 (R61):A review of R61's medical record revealed an admission into the facility on 9/2/25 with diagnoses that included cystitis, heart failure, diabetes, and heart disease. A review of R61's Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 9/15 that indicated moderately impaired cognition, and the Resident used a wheelchair for mobility. On 9/24/25 at 9:46 AM, Resident 61 was observed in his room, seated in a wheelchair. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about any concerns he had about his care at the facility and was asked about any issues with his room. The Resident reported that the sliding bathroom door would not open, he could close it with difficulty but reported he could not get it back open. The Resident was able to propel himself around in the room and went to the partially open bathroom door and was unable to push it open. The door was observed and pushed on but would not open further. The Resident reports that with the door partially closed, Now I can't get in there. The door was able to be closed a little further with difficulty but when pushed on by the Resident, the door would not open for him. The Resident reported that being seated in the wheelchair, he did not have the momentum to open the door and reported he was afraid of getting shut in the bathroom and not being able to get himself out. The Resident reported that he would have to close his bedroom door if he were to use the bathroom and hopes that no one walks in to the room. When asked how long the issue with his door had been going on, the Resident reported that the door had problems since he had been there. When asked if staff were aware, he indicated yes because they sometimes go in there and they were aware how hard it is to open the door. The Resident stated, I showed some guy who I thought was from maintenance, that he could not close the door. Resident #128 (R128):A review of R128's medical record revealed an admission on [DATE] with diagnoses that included dementia, diabetes, respiratory failure, and stroke. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 9/15 that indicated moderately impaired cognition and the Resident needed substantial/maximal assistance with bathing, upper body dressing, personal hygiene, roll left and right and was dependent on a helper for toileting hygiene, lying to sitting, and transfers. On 9/23/25 at 10:49, an observation was made of Resident #128 lying in bed. The head of the bed was elevated slightly. The Resident had a meal tray on an overbed table in front of her. The meal had been eaten. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about the care she received at the facility and if she had any concerns. A concern the Resident reported was that the bathroom sliding door was too difficult to get open and that staff would kick at it to try to open it. The Resident said that the issue with the door was recurring, and they had fixed it before, but it happened again. The Resident reported the blinds did not work and they could not adjust the slats how the Resident wanted in opened or closed or partially opened. The Resident reported the blinds have been an issue for a couple months or longer. On 9/23/25 at 11:13 AM, an interview was conducted with Nurse EE, while in the room with the Nurse, the Resident expressed concern of the blinds not working and the bathroom door not working properly. The Resident stated that there was no way to move the slats of the blinds up and down. Nurse EE reported that the twist rod to adjust the slats of the blinds was broken and needed to be replaced. The Nurse reported the blinds had been an issue for two or three months and it had been conveyed to Maintenance personnel. The Resident complained of the bathroom door was not opening. The Nurse tried to open the door, but it was very difficult to open and reported they had fixed it once already. Out in the hall, the Nurse was asked if there was a way to make a work order, the Nurse (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported that they changed the screen on the computer, and they did not have a way to make a maintenance work order and that only housekeeping could do that with an app on their phone. On 9/25/25 at 11:01 AM, an interview was conducted with Maintenance Director (MD) C regarding Resident 61 and 128's blinds and bathroom doors. The MD was asked about the bathroom door and reported that Resident 128's door was fixed yesterday, was an ongoing issue and had been adjusted to keep the problem from recurring. The blinds were observed, and it was reported by the MD that they were unaware that the blinds were an issue for Resident 128. The MD reported that they would have it fixed or replace the blinds.An observation was made in Resident 61's room of the bathroom door that was very difficult to open. The MD reported to the Resident that they would get it fixed for him and explained to the Resident that he should be able to open the door with a light push.The MD was asked about the system for staff to put in a work order for the doors and blinds. The MD reported that they can tell us, but they also need to put a work order on the computer. It was reviewed that the Nurse indicated that there was no longer a way to put the work order on the computer and that housekeeping were the ones to put in the work orders. The MD reported that the computer should have the app on the computer, or they can use the phone app by putting their phone camera to the bar code. An observation was made with the MD of the code that was hung in the hallway by a computer and showed how the phone would take a picture of the code, and it goes to the system used by maintenance department to be aware of maintenance issues. The computer in the hall where Resident 61 and 128 resided was observed with the MD and the Nurse in the hallway. The computer did have the app on the screen. The MD stated, They should be using the system and if they tell us, they should also put it in the system so we can follow up on it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Past Non-Compliance (PNC) was identified during investigation of the deficient practice and was accepted by the survey team upon exit from the facility for this citation. Following discussion with the State Manager, Past Non-Compliance was accepted with a Compliance Date of 6/25/25. Based on observation, interview and record review, the facility failed to ensure Resident safety when care-planned interventions were not followed for bed mobility for one resident (#128) of three reviewed for falls and accidents, resulting in Resident 128 falling from the bed, pain to the knee and need for x-rays.Findings include:Resident #128 (R128): A review of R128's medical record revealed an admission on [DATE] with diagnoses that included dementia, diabetes, respiratory failure, and stroke. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 9/15 that indicated moderately impaired cognition and the Resident needed substantial/maximal assistance with bathing, upper body dressing, personal hygiene, roll left and right and was dependent on a helper for toileting hygiene, lying to sitting, and transfers. On 9/23/25 at 10:49, an observation was made of Resident #128 lying in bed. The head of the bed was elevated slightly. The Resident was interviewed, answered questions and engaged in conversation. The Resident did not have her call light in reach. When asked if she could reach it where it was observed positioned on the upper corner on the side of the mattress fitted sheet, the Resident reported that if she tried to roll over, she was afraid she would roll off the bed again. When queried about rolling off the bed, the Resident reported that staff had pushed her over when assisting the Resident with turning in bed and stated, She said I rolled over, I was trying to lay on my side, but she pushed me over, I was reaching for the handle of the chair and she pushed me. The Resident reported that they were to use two people to turn me and the CNA repositioned her by herself and stated, Did x-rays, no broken bones but it affected my right knee, and complained of having pain in her right knee since the fall off the bed. A review of Resident 128's incident documentation revealed the following:-Date of fall, 5/22/25 at 11:15 AM, Incident Description: This nurse was called to the room by hospice RN. Hospice CENA was doing care on guest. Guest likes to hang on to the chair. She was on her right side. Her right side and slipped off the bed and she landed on it and rolled to her back. Guest denies pain. All extremities move at baseline. Guest's 3rd, 4th, and 5th toenails were removed in the fall. -Dated 5/23/25 Fall Assess revealed, .Root cause: Guest was receiving care by 1PA (one person physical assist) and slipped off bed on the right side of bed. Intervention: Care plan updated and changed bed mobility to 2PA. IDT (interdisciplinary team) met and care plan updated.-Date of incident 6/18/25 at 8:15 PM, Nursing Description: CNA was assisting guest in brief change, guest was reaching for the chair and pulling and working against CNA during incident. Guest pulled herself off the right side of the bed and onto the floor. Witnessed and guest did not hit her head. She is painful, has skinned her right knee and the ball of her right toe.-Dated 6/19/25 Fall Assess revealed, .Guest had complaints of pain to her right knee and right 1st foot digit. Xray of right knee was ordered and negative for fracture, but shows moderate osteoarthritis of the right knee. Root cause: Guest was receiving care by 1PA and pulled herself off bed on the right side of bed. Intervention: Care plan reviewed and updated to educate staff of guests bed mobility requires 2PA. A review of Resident 128's care plan report revealed a focus for Risk for falls r/t (related to) unsteady gait, . with interventions that included Bed Mobility: 2PA, revision on 5/22/25. On 9/25/25 at 2:35 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident 128's falls from the bed. The Resident's fall from the bed during care with the Hospice CNA, care plan had been updated to two person assist with bed mobility on 5/22/25, then on 6/18/25 CNA DD was assisting with bed mobility and the Resident fell from the bed, the CNA did not have two people to assist with bed mobility was reviewed with the DON. The care plan had not been followed by the CNA during bed mobility. The DON reported that they completed education with the (continued on next page)

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	235171	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Grand Blanc	3139 East Baldwin Road Grand Blanc, MI 48439

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA for not following the care plan and then completed education with all the CNAs. The DON reported they did a sweep of all residents bed mobility and care plans reviewed and updated as needed. The DON reported that CNAs do a room to room report between shifts and update on any changes and stated, The need to look at the care plan for any changes, it could change at any time. The DON reported they had another resident with a fall and stated, The CNA did follow care (plan) and stated, We did audits and made sure we were compliant with it. The Administrator presented the corrective action plan regarding Resident 128's fall on 6/18/25 when the care plan had not been followed during bed mobility with two persons assist. The facility attained and maintained compliance for F689 with a compliance date on 6/25/25.1.) Resident A (R128) was assessed by the nurse manager on 6/19 and no acute injuries were noted. All residents have the potential to be affected.2.) A one time review of residents bed mobility and fall care plans were reviewed on 6/19 by the nurse managers to ensure they were appropriate and were updated as needed. Nursing staff were re-educated on bed mobility. All residents reviewed for bed mobility as one time audit on 6/19/25.Education completed on 6/20/25 with the Topic: Please read and follow careplans for all residents. Follow bed mobility careplans and Kardexs (care guides), with signed signatures of CNAs and Performance Education for CNA DD on 6/20/25.3.) System change: Bed mobility will be reviewed for all new admissions and quarterly with MDS and quarterly as needed.4.) DON/Designee will review 5 residents weekly x 6 to ensure that bed mobility is appropriate and followed per care plan. Any nonadherence will result in 1:1 education. All audits will be reviewed with the QA committee. Audits completed on 7/3/25, 7/10/25, 7/17/25, 7/24/25, 7/31/25 and 8/7/25.Date of compliance of the plan of correction: 6/25/25. The State Surveyor verified the documentation provided by the facility and conducted interviews with facility staff regarding following care planned interventions and staff were knowledgeable about the facility policies. Other Residents were reviewed for falls and noncompliance was not identified with F-689.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review the facility failed to ensure nurses completed yearly competencies and training for 3 of 5 nurses, reviewed for education and competencies, resulting in the potential for nurses to lack the necessary skills and qualifications to adequately care for the needs of the residentsFacility Sufficient and Competent Nurse Staffing On 9/24/2025 at 2:30 PM, during an interview with Staff Education Nurse M she said the nurses had a 2-day classroom orientation where they completed online computer training and then they were assigned to a preceptor on the nursing units and were to complete competencies. Nurse M was asked if the staff completed hands on competencies and she said she went over Personal Protection Equipment/PPE's, Hand Hygiene, electronic medical record/emr documentation, blood glucose checks, bladder scanner, and the Ekg machine. She said IVs were reviewed with the Nurse and they verbalized back the process. On 9/24/2025 at 3:00 PM, Human Resources/HR Manager X was asked for education files for Nurses V and W. A record review of the education files for Nurses V and W revealed the Nurse Skill/Competencies Assessment form revised 3/25, had 58 competency check off items listed. It did not specify whether a nurse was an RN or LPN. There was a category for Assessment and under Assessment Satisfactory and Unsatisfactory were listed. Each Nurse V and W placed their initials next to the items completed under the Satisfactory category. There was no indication another nurse observed their competency and deemed them competent.Nurse V's Nurse skills/Competencies Assessment was checked in the Annual box. She initialed and signed that she completed all of her orientation hands on competency skills on 6/10/2025 except for Trach care, Suctioning-trach/oral/pharyngeal, C-Pap/BiPap, and Insertion of G-tube, they were not checked off. Staff Education Nurse E signed the document on 6/10/2025, but the Evaluator signature box was empty.Nurse W's Nurse skills/Competencies Assessment was not identified as Initial/New hire, Annual, or Other; each box was blank. Nurse W initialed and signed that she completed all of the hands-on competency training in one day on 5/30/2025, except for Trach care, it was left blank. Nurse E signed the document on 6/2/2025 as the Evaluator 2 days later.On further review of the Nurse Skills/Competencies Assessment form it was noted there was an entry for IV medication, IV Insertion (RN), IV administration- label, hang, IVP, IV documentation, and IV dressing change. There was no competency for maintenance of the IV line. There was no competency for Central Lines including PICC/Peripherally Inserted Central Catheter's.The entries for PPE and Hand Hygiene were marked as completed by Nurses V and W; and there was no document confirming an in-person hands on competency for each had been completed. On 9/25/2025 at 11:28 AM, Assistant Director of Nursing AA was interviewed about nursing orientation. She said it started with a 2-day computer training and then they would be assigned to the floor to complete competencies. At this time, competencies for Nurses T, U and G were requested. On 9/25/2025 at 11:40 AM, the Administrator and Corporate Nurse E were interviewed related to the nurses V and W checking themselves off as Satisfactory on their competencies. The Competency forms were reviewed for Nurses V, and W. The Nurses initialed they satisfactorily completed the competencies and then signed and dated it was done. There were no specific dates when each item was completed; only when the entire competency was completed and then the Staff Education Nurse signed the form. The Administrator and Corporate Nurse E were asked how it was possible for a Nurse to say they performed a skill/task Satisfactory and also to complete all of the skills in one day. They were asked if orientation was one day on the floor and they said it was not. There was no explanation as to why the nurses were checking themselves off as Satisfactory on their competencies. On 9/25/2025 at 1:50 PM, Human Resources/HR Manager X was observed in her office with Nurse G who was sitting at the HR Manager's desk. The Human Resources Manager was heard asking Nurse G to complete and sign her yearly competency because HR X couldn't find one in the Nurses education file. Nurse G was (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed to have a blank copy of a Nurse Skills/Competencies Assessment form in front of her. Upon entering the room, this Surveyor asked Nurse G how long she had worked at the facility and she said 3 years. HR X was asked if there were any competencies in Nurse G's file and she stated, No. The Administrator entered the office and said they were also looking in the Staff development/education office for more competencies. On 9/25/2025 at 3:45 PM a competency for Nurse G was identified as being located by the Administrator. On 9/26/2025 at 9:30 AM, the Director of Nursing said there was no staffing policy. A review of the Facility Assessment dated revised 7/1/2025 by the Administrator identified the following: Purpose: The Facility assessment is a complete review of internal human and physical resources required by the facility to care for residents competently during day to day and emergency operations. There are three components to the review: 1. Resident profile. 2. Services and care offered. 3. Facility resources needed to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, education and training. Nursing Services: The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A facility must develop, implement, and maintain an effective training program for all new and existing staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 store and handle medications in accordance with acceptable pharmaceutical standards of practice: 1) for 2 of 3 medication rooms 2) ensure medication refrigerators were clean, and 3) ensure medications were stored to professional standards of practice, including vaccinations, resulting in the potential for contamination of medications, incorrect administration of medications, a lack of therapeutic benefits necessary to promote healing for residents, increase the potential for adverse effects. Facility Medication Storage and Labeling: On [DATE] at 9:28 AM, during a review of the South over-the-counter medication and supplies storage room with Assistant Director of Nursing/ADON AA, several expired items were identified: Multiple packets of A&D ointment, triple antibiotic and bacitracin all dated 5/2025. In addition, there were gauze dressings dated 12/2024. Nurse AA said she would remove and discard the items. Observed on several different shelves and supply bins were lancet devices mixed with unrelated items. It appeared they spilled into multiple different boxes and bins. Nurse AA said they should not have been there and needed to be picked up. On [DATE] at 9:43 AM a review of the South medication room for prescription medications with ADON AA identified a medication refrigerator under the counter. The refrigerator was observed to have spilled items on the top edge and inside bottom areas. In addition, the refrigerator was stacked full inside with a majority of vaccinations (Influenza, Pneumonia and several others). Upon touching the outside box of an Influenza vaccination, it felt slightly damp. The refrigerator was 40 degrees Fahrenheit, but it was unclear what the temperature inside the large stacks of vaccinations were. The refrigerator was very full. On [DATE] at 10:05 AM, a review of the North medication room with ADON AA it was observed the countertop under the cabinets and over the refrigerator was covered in sanding dust. It appeared holes in the wall were filled and sanded and debris was left on the counter covering items on the counter; ADON AA said she would make sure it was cleaned up. Upon review of the refrigerator, it was noted to have only a few items stored there. ADON AA said they might store some of the vaccinations in the refrigerator to alleviate the amount in the South hall medication room refrigerator. On [DATE] at 10:51 AM, Corporate Clinical Nurse E was interviewed related to the medication storage issues, including the South hall medication room refrigerator that was full with vaccinations, she said they needed another refrigerator. On [DATE] at 2:45 PM, ADON AA said some of the vaccinations had been moved from the South Hall medication room refrigerator to the North Hall medication refrigerator, but they were still looking at obtaining a new refrigerator. On [DATE] at 11:30 AM, Maintenance Director C was interviewed and said, he had corrected the issue with construction dust on the surfaces in the North Medication room and it should not have (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	happened. On [DATE] at 9:47 AM, an observation was made during medication administration observation with Nurse GG giving Resident 144 their medication. An observation was made of two boxes with a prescription label and a small container with a prescription label on it. The items were on a shelf next to the Resident's bed. The Nurse was asked about the items. Upon inspection the Nurse indicated it was lidocaine gel and nystatin powder for Resident 144. The Nurse reported that it should not be left out of the medication cupboard and had opened the medication cabinet in the room with a key and then locked the medication in. On [DATE] at 11:40 AM, an interview was conducted with the Assistant Director of Nursing (ADON) AA regarding medication storage. The ADON was asked about storage of topical creams, ointments and treatments stored with oral medication. The ADON reported topical medication can be stored in a separate box, on a separate shelf, or in the original box/bag, the medication could then be stored with the oral medication. The ADON reported that a box or bag would be a barrier between the oral medication and the other routes. An observation was made with the ADON of Resident 144's medication cupboard in the room. The nystatin powder was not in a bag or box and was positioned next to oral medication. The ADON reported the nystatin powder should not be next to the oral medication. When asked about the medication at the bedside, the ADON reported that medication was to be stored in the locked area. On [DATE] at 12:15 PM, an observation was made in Resident 24's room with ADON AA. An observation was made of Voltaren gel (a topical nonsteroidal anti-inflammatory drug often used to relieve joint pain associated with osteoarthritis) on the counter of the sink near the Resident's bed, two containers, and one container across the room on a counter space. The ADON stated, We can't have medication that is not locked, and explained to the Resident, who was in the room at the time and expressed it was his own personal gel, that they would get him a lock box to keep it safe. On [DATE] at 3:09 PM, the concern of storage of medication was reviewed with the Director of Nursing (DON). The DON indicated that the medication cannot be left out and the plan for Resident 24 was to care plan for it (Voltaren gel), get a lock box and assessment to do the gel himself.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide palatable food products and meet residents' food preferences, for 7 residents (24, 61, 72, 74, 89, 121 and 143) of 7 residents reviewed for food and choices and a Confidential Group of Residents, resulting in residents' feelings of frustration and anger. Resident #61 (R61) A review of R61's medical record revealed an admission into the facility on 9/2/25 with diagnoses that included cystitis, heart failure, diabetes, and heart disease. A review of R61's Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 9/15 that indicated moderately impaired cognition, and the Resident used a wheelchair for mobility. On 9/24/25 at 9:46 AM, Resident 61 was observed in his room, seated in a wheelchair. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about any concerns he had about his care at the facility and was asked about any issues with the food served. The Resident stated, Breakfast this morning was not cooked all the way through with the sausages. It was cooked on one side; it was half cooked. It was obviously not cooked all the way, and reported his wife had the same issue. When asked if the sausage was warm, the Resident indicated it was warm, but it was pink on the inside and expressed concern about getting sick from eating undercooked meat. On 09/23/2025 at 11:56 AM until ~(approximately)12:28 PM During dining observation, R24 was served his meal without silverware and had to request the staff to supply some. A review of R24's meal ticket (#309) revealed, 1 Cottage cheese (#8 scoop) was to be served and was observed to be missing from the meal. When R24 was asked about his meal and the cottage cheese he stated, I guess I just don't get that. According to a review of R24's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to diabetic ketoacidosis (DKA) (a buildup of ketones in the blood caused by elevated blood sugar making the blood acidic), weakness and IV Vancomycin infusion (42 days remaining on IV). R24's minimum data set (MDS) record revealed Brief Interview of Mental status (BIMs) score of 12/15 indicated the resident had moderately impaired cognition. Medical diagnosis included: Sepsis (the bodies extreme response to infection), Methicillin Resistant Staphylococcus Aureus (MRSA) infection (bacteria that is resistant to many antibiotics, including methicillin), diabetes mellitis type 2, calculus of kidney (kidney stones), Heart failure, acute and sub-acute infective endocarditis. A review of R24's Kardex (resident care guide) revealed, Provide diet per physician order; regular diet, regular texture, thin liquids; high protein food items added to meal ticket to promote wound healing; low sodium/DM modified diet; supplements as ordered to promote wound healing. On 09/23/2025 at 11:56 AM until ~12:28 during dining observation, R72 was served her meal from the opposite side of the table by CNA I. R72 picked up a piece of bread form the tray, and held it in her hand, and stated, Oh bread; do I have any butter? while turning to her left and right. The resident seated next to her replied, You do not, but I have some and handed butter to R72. A review of R72's lunch ticket (#349) revealed, 1 French Fries (1/2 cup) and 1 butter (1 each) were to be served, and the ticket listed an alert: Blind- describe meal to resident., which was highlighted in yellow. Observed on R72's plate was rice (not listed on ticket) and missing butter. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a review of R72's medical record, the resident was admitted to the facility 08/26/2025 for skilled nursing care related to a fracture of the left femur, diabetes mellitis type 2 (insulin resistance causing elevated blood sugar) and chronic obstructive pulmonary disease. A review of R72's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Additional medical diagnoses included glaucoma (impaired vision) and anxiety. A review of R72's care plan revealed: Focus: Alteration in nutritional status related to weakness and debility . Guest at risk for weight changes related to fluid status shifts, edema, and diuretic therapy prefers to eat with her hands & wears her own clothing protector; Date Initiated: 09/04/2025 with an Intervention: Provide diet per physician order; Regular diet, regular texture, thin liquids, low sodium/DM (diabetes) modified, guest blind- describe meal to guest; Date Initiated: 08/26/2025 Revision on: 08/29/2025. A review of R72's Kardex (resident care guide) revealed: Eating and Nutrition: Provide diet per physician order; Regular diet, regular texture, thin liquids low sodium/DM modified; guest blind-describe meal to guest. On 09/23/2025 at 11:56 AM until ~12:28 during dining observation, R89 was served a meal that included her entrée' and 2 bowls, one with broccoli and cheese and one with tomato soup. A review of R89's meal ticket (#40) revealed, neither requested soup. R 89's meal ticket further revealed, 1 Cottage cheese (#8 scoop) was to be served and was observed to be missing from the meal. When R89 was asked about her meal she stated, I don't know why I got two different soups and said that she did not know where her cottage cheese was, she stated I guess this is what I am getting. According to a review of R89's medical record, the resident was admitted to the facility on [DATE] for nursing care. R89's Brief Interview of Mental status (BIMs) score of 6/15 indicated the resident was severely cognitively impaired, needed some assistance with care and was independent with eating. Medical diagnosis included: Atherosclerotic heart disease (ASHD), Atrial Fibrillation (irregular heart rhythm), non-Alzheimer's dementia, and depression. A review of the physician orders for Resident #89 revealed an order for a Regular diet, Regular Texture, thin consistency (fluids). On 09/24/2025 at 1:48 PM, during an interview with R121 she said her lunch was good but explained it was not hot. She said she eats in her room and does not go to the dining area. On 09/24/2025 at 8:27 AM, during a follow up interview with R121 about how breakfast was on this day, she said it tasted ok, but it was lukewarm. R121 further explained that at least half her meals are served that way. She reports that she has let the staff know and that it is still 50 % of the time. According to a review of R121's medical record, the resident was admitted to the facility on [DATE] for nursing care related to a fracture of her right humerous (arm), fracture of T11-T12 spine. R121's Brief Interview of Mental status (BIMs) score of 9/15 indicated the resident was moderately cognitively impaired. Medical diagnosis included: chronic obstructive pulmonary disease (COPD), diabetes mellitis type 2, Aphasia related to cerebral infarct. A review of R121's Kardex revealed, Eating and nutrition. Provide diet per physician order; regular (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diet, regular texture, thin liquids; DM/low sodium modified. A review of R121's care plan revealed: Focus: Risk for falls r/t weakness and debility; interventions: Encourage good nutrition and hydration in order to promote healthier skin. Focus: Alteration in nutritional status related to weakness and debility; interventions: Honor advance directives related to nutrition/hydration; Honor food preference. On 09/24/2025 at 1:14 PM, during an interview with R143 she reported that she had just vomited. R 143 explained that she had not felt well since breakfast and reported I had under cooked sausage, she said it was not done all the way and that she had eaten half of it when she noted the middle was not cooked all the way. R143 further explained that she had told this to CNA H. R143 reported that when she had shown CNA H the sausage, that CNA H agreed the sausage did not look fully cooked. R143 continued to explain that she attempted to eat lunch and had hoped that might calm her nausea. R143 reported that when she uncovered her fruit there were fruit flies present, and she was unable to eat after that. R143 further reported that last week, she received her meal tray and that she found a paper clip, in her fruit cup. R143 said that she was in food service before, so she knew the challenges. She stated, I asked to talk to the kitchen manager and said that Kitchen Managers (2) came and talked to her. She said she explained to them that, If the paperclip got into the disposal of the kitchen, it could cause a lot of damage, and think what it could do to my body. R143 said that they apologized to her. According to a review of R143's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to left knee replacement surgery. A review of R143's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMs) score of 14 out of 15, indicating the resident was cognitively intact. Medical diagnosis included diabetes mellitis type 2, hypertension, unspecified heart failure, and chronic kidney disease stage 3 (mild to moderate damage to kidneys). On 09/24/2025 at 1:27 PM, CNA H was asked about R143's breakfast tray (on 09/24/2025) and if she observed the sausage that was served, and she agreed that she had. CNA H was asked if she had agreed with R143 that her sausage was underdone, and she replied, yes. CNA H further stated, all of my residents sausage looked that way at breakfast. A review of R143's care plan revealed: Focus: .has impairment to skin integrity r/t fragile integument impaired mobility. ; intervention: Encourage good nutrition and hydration in order to promote healthier skin. Focus: Alteration in nutritional status related to weakness and debility.; intervention: Honor advance directives related to nutrition/hydration; Honor food preference; Provide diet per physician order; regular diet, regular texture, thin liquids DM modified. On 09/24/2025 at ~2:30 PM, during a meeting with confidential group of residents, it was revealed (continued on next page)

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	235171	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Grand Blanc	3139 East Baldwin Road Grand Blanc, MI 48439

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that there was a consensus of the residents present that meals being served to residents that dine in their rooms are being served colder than was desired. Residents reporting that, Breakfast is the worst, with the consensus that most residents eat breakfast in their rooms and not the dining room. Other resident concerns that were related to food and service included: My oatmeal is like soup before I ever put anything in it. The print is small on the menus given out. Not enough variety in the menu On 9/25/2025 at 3:07 PM to ~(approximately) 03:30 PM, during an interview with Kitchen Manager A and Culinary Specialist B, they were asked if residents had concerns about the temperature of the food. Kitchen Manager A said they did at times and if a resident had concerns, they would talk to the resident. The Kitchen Manager A said there was a food committee once a month and usually 10-15 residents attended and sometimes, they mentioned cold food. When asked specifically about resident concerns about the sausage served on 09/24/2025 during breakfast service, Culinary Specialist B stated, it temped in the kitchen. Kitchen Manager A and Culinary Specialist B were asked about the resident reported concern over finding a paperclip in her fruit last week, Culinary Specialist B responded, we talked to a resident, I don't recall which one or what was in the food she further explained, we did talk to them and they were ok. When Culinary Specialist B was asked how a paper clip would get into a resident's food from the kitchen service, she stated, we use paper clips on meal tickets. Both Kitchen Manager A and Culinary Specialist B report after speaking with the resident that they no longer used paper clips on meal tickets. According to a review of facilities resident council meeting minutes from May 29th, 2025: Dietary: guests asked to have dietary management present to discuss their food concerns in general. 'the chicken is overcooked. The potatoes in the potato salad were hard. The eggs are cooled too' . According to a review of facilities resident council meeting minutes from June 27th, 2025: Dietary: guests are still having concerns about dietary issues. The issues are that chicken is still being served overcooked, and eggs during breakfast are still being served cold. According to a review of facilities resident council meeting minutes from July 15th, 2025: . Resident states she must go to the kitchen to receive her breakfast tray if she wants to receive it at a decent time. According to a review of facilities resident council meeting minutes from August 29th, 2025: Dietary: No grievances needed to be filed with dietary, .ran food committee after council, she was able to answer questions and concerns. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/23/2025 at 11:56 AM until ~(approximately)12:28 PM During dining observation, R24 was served his meal without silverware and had to request the staff to supply some. A review of R24's meal ticket (#309) revealed, 1 Cottage cheese (#8 scoop) was to be served and was observed to be missing from the meal. When R24 was asked about his meal and the cottage cheese he stated, I guess I just don't get that. According to a review of R24's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to diabetic ketoacidosis (DKA) (a buildup of ketones in the blood caused by elevated blood sugar making the blood acidic), weakness and IV Vancomycin infusion (42 days remaining on IV). R24's minimum data set (MDS) record revealed Brief Interview of Mental status (BIMs) score of 12/15 indicated the resident had moderately impaired cognition. Medical diagnosis included: Sepsis (the bodies extreme response to infection), Methicillin Resistant Staphylococcus Aureus (MRSA) infection (bacteria that is resistant to many antibiotics, including methicillin), diabetes mellitis type 2, calculus of kidney (kidney stones), Heart failure, acute and sub-acute infective endocarditis. A review of R24's Kardex (resident care guide) revealed, Provide diet per physician order; regular diet, regular texture, thin liquids; high protein food items added to meal ticket to promote wound healing; low sodium/DM modified diet; supplements as ordered to promote wound healing. On 09/23/2025 at 11:56 AM until ~12:28 during dining observation, R72 was served her meal from the opposite side of the table by CNA I. R72 picked up a piece of bread form the tray, and held it in her hand, and stated, Oh bread; do I have any butter? while turning to her left and right. The resident seated next to her replied, You do not, but I have some and handed butter to R72. A review of R72's lunch ticket (#349) revealed, 1 French Fries (1/2 cup) and 1 butter (1 each) were to be served, and the ticket listed an alert: Blind- describe meal to resident., which was highlighted in yellow. Observed on R72's plate was rice (not listed on ticket) and missing butter. According to a review of R72's medical record, the resident was admitted to the facility 08/26/2025 for skilled nursing care related to a fracture of the left femur, diabetes mellitis type 2 (insulin resistance causing elevated blood sugar) and chronic obstructive pulmonary disease. A review of R72's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Additional medical diagnoses included glaucoma (impaired vision) and anxiety. A review of R72's care plan revealed: Focus: Alteration in nutritional status related to weakness and debility . Guest at risk for weight changes related to fluid status shifts, edema, and diuretic therapy prefers to eat with her hands & wears her own clothing protector; Date Initiated: 09/04/2025 with an Intervention: Provide diet per physician order; Regular diet, regular texture, thin liquids, low sodium/DM (diabetes) modified, guest blind- describe meal to guest; Date Initiated: 08/26/2025 Revision on: 08/29/2025. A review of R72's Kardex (resident care guide) revealed: Eating and Nutrition: Provide diet per physician order; Regular diet, regular texture, thin liquids low sodium/DM modified; guest blind-describe meal to guest. On 09/23/2025 at 11:56 AM until ~12:28 during dining observation, R89 was served a meal that included her entrée' and 2 bowls, one with broccoli and cheese and one with tomato soup. A review of R89's meal ticket (#40) revealed, neither requested soup. R 89's meal ticket further (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed, 1 Cottage cheese (#8 scoop) was to be served and was observed to be missing from the meal. When R89 was asked about her meal she stated, I don't know why I got two different soups and said that she did not know where her cottage cheese was, she stated I guess this is what I am getting. According to a review of R89's medical record, the resident was admitted to the facility on [DATE] for nursing care. R89's Brief Interview of Mental status (BIMs) score of 6/15 indicated the resident was severely cognitively impaired, needed some assistance with care and was independent with eating. Medical diagnosis included: Atherosclerotic heart disease (ASHD), Atrial Fibrillation (irregular heart rhythm), non-Alzheimer's dementia, and depression. A review of the physician orders for Resident #89 revealed an order for a Regular diet, Regular Texture, thin consistency (fluids). On 09/24/2025 at 1:48 PM, during an interview with R121 she said her lunch was good but explained it was not hot. She said she eats in her room and does not go to the dining area. On 09/24/2025 at 8:27 AM, during a follow up interview with R121 about how breakfast was on this day, she said it tasted ok, but it was lukewarm. R121 further explained that at least half her meals are served that way. She reports that she has let the staff know and that it is still 50 % of the time. According to a review of R121's medical record, the resident was admitted to the facility on [DATE] for nursing care related to a fracture of her right humerous (arm), fracture of T11-T12 spine. R121's Brief Interview of Mental status (BIMs) score of 9/15 indicated the resident was moderately cognitively impaired. Medical diagnosis included: chronic obstructive pulmonary disease (COPD), diabetes mellitis type 2, Aphasia related to cerebral infarct. A review of R121's Kardex revealed, Eating and nutrition. Provide diet per physician order; regular diet, regular texture, thin liquids; DM/low sodium modified. A review of R121's care plan revealed: Focus: Risk for falls r/t weakness and debility; interventions: Encourage good nutrition and hydration in order to promote healthier skin. Focus: Alteration in nutritional status related to weakness and debility; interventions: Honor advance directives related to nutrition/hydration; Honor food preference. On 09/24/2025 at 1:14 PM, during an interview with R143 she reported that she had just vomited. R 143 explained that she had not felt well since breakfast and reported I had under cooked sausage, she said it was not done all the way and that she had eaten half of it when she noted the middle was not cooked all the way. R143 further explained that she had told this to CNA H. R143 reported that when she had shown CNA H the sausage, that CNA H agreed the sausage did not look fully cooked. R143 continued to explain that she attempted to eat lunch and had hoped that might calm her nausea. R143 reported that when she uncovered her fruit there were fruit flies present, and she was unable to eat after that. R143 further reported that last week, she received her meal tray and that she found a paper clip, in (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her fruit cup. R143 said that she was in food service before, so she knew the challenges. She stated, I asked to talk to the kitchen manager and said that Kitchen Managers (2) came and talked to her. She said she explained to them that, If the paperclip got into the disposal of the kitchen, it could cause a lot of damage, and think what it could do to my body. R143 said that they apologized to her. According to a review of R143's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to left knee replacement surgery. A review of R143's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMs) score of 14 out of 15, indicating the resident was cognitively intact. Medical diagnosis included diabetes mellitis type 2, hypertension, unspecified heart failure, and chronic kidney disease stage 3 (mild to moderate damage to kidneys). On 09/24/2025 at 1:27 PM, CNA H was asked about R143's breakfast tray (on 09/24/2025) and if she observed the sausage that was served, and she agreed that she had. CNA H was asked if she had agreed with R143 that her sausage was underdone, and she replied, yes. CNA H further stated, all of my residents sausage looked that way at breakfast. A review of R143's care plan revealed: Focus: .has impairment to skin integrity r/t fragile integument impaired mobility. ; intervention: Encourage good nutrition and hydration in order to promote healthier skin. Focus: Alteration in nutritional status related to weakness and debility.; intervention: Honor advance directives related to nutrition/hydration; Honor food preference; Provide diet per physician order; regular diet, regular texture, thin liquids DM modified. On 09/24/2025 at ~2:30 PM, during a meeting with confidential group of residents, it was revealed that there was a consensus of the residents present that meals being served to residents that dine in their rooms are being served colder than was desired. Residents reporting that, Breakfast is the worst, with the consensus that most residents eat breakfast in their rooms and not the dining room. Other resident concerns that were related to food and service included: My oatmeal is like soup before I ever put anything in it. The print is small on the menus given out. Not enough variety in the menu On 9/25/2025 at 3:07 PM to ~(approximately) 03:30 PM, during an interview with Kitchen Manager A and Culinary Specialist B, they were asked if residents had concerns about the temperature of the food. Kitchen Manager A said they did at times and if a resident had concerns, they would talk to the resident. The Kitchen Manager A said there was a food committee once a month and usually 10-15 residents attended and sometimes, they mentioned cold food. When asked specifically about resident concerns about the sausage served on 09/24/2025 during breakfast service, Culinary Specialist B stated, it temped in the kitchen. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Kitchen Manager A and Culinary Specialist B were asked about the resident reported concern over finding a paperclip in her fruit last week, Culinary Specialist B responded, we talked to a resident, I don't recall which one or what was in the food she further explained, we did talk to them and they were ok. When Culinary Specialist B was asked how a paper clip would get into a resident's food from the kitchen service, she stated, we use paper clips on meal tickets. Both Kitchen Manager A and Culinary Specialist B report after speaking with the resident that they no longer used paper clips on meal tickets. According to a review of facilities resident council meeting minutes from May 29th, 2025: Dietary: guests asked to have dietary management present to discuss their food concerns in general. 'the chicken is overcooked. The potatoes in the potato salad were hard. The eggs are cooled too' . According to a review of facilities resident council meeting minutes from June 27th, 2025: Dietary: guests are still having concerns about dietary issues. The issues are that chicken is still being served overcooked, and eggs during breakfast are still being served cold. According to a review of facilities resident council meeting minutes from July 15th, 2025: . Resident states she must go to the kitchen to receive her breakfast tray if she wants to receive it at a decent time. According to a review of facilities resident council meeting minutes from August 29th, 2025: Dietary: No grievances needed to be filed with dietary, .ran food committee after council, she was able to answer questions and concerns. Resident #74 Food On 9/23/2025 at 10:57 AM, Resident #74 was observed sitting in her room and stated, This morning I got my breakfast, and it was cold. When asked how the resident's other meals were she stated, They serve soup and it's not bad, but some of the meals are bad. I bought peanut butter yesterday so I could eat something. A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #74 was admitted to the facility on [DATE] with diagnoses: Heart disease, COPD, anxiety, depression, and GERD (gastroesophageal reflux disease). The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 14/15 and the resident needed some assistance with care and was independent with eating. A review of the physician orders for Resident #74 revealed an order for a Regular diet, Regular Texture, thin consistency (fluids), start date 9/22/2025 and revised 9/23/2025. A review of the Care Plans for Resident #74 identified the following: Alteration in nutritional status related to co-morbidities. date initiated 1/19/2025 and revised (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/15/2025 with Interventions including: Honor food preference, date initiated 1/19/2024. On 9/25/2025 at 3:07 PM, during an interview with Kitchen Manager A and Culinary Specialist B, they were asked if residents had concerns about the temperature of the food. Kitchen Manager A said they did at times and if a resident had concerns they would talk to the resident. The Kitchen Manager A said there was a food committee once a month and usually 10-15 residents attended and sometimes they mentioned cold food.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that appropriate communication between the hospice agency and the facility was accessible in a timely manner for one resident (Resident #39) of the three sampled residents reviewed for hospice care.Findings include: Resident #39 (R39): On 09/23/25 at approximately 11:45 AM, during the initial tour, the surveyor observed R39 with a caregiver and verified that she was the hospice nurse caring for R39 today. However, upon entering the facility at 10:00 AM, the CMS Form 802 submitted to the surveyors indicated that Resident R39 was not coded as receiving hospice care services. A review of records on 9/24/25 at 11:30 AM revealed that R39 was [AGE] years old, admitted to the facility on [DATE] with the diagnosis of Senile Degeneration of Brain, Transient Ischemic Attack (TIA), Vascular Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety in addition to other diagnoses. R39' Brief interview of Mental Status BIMS Score dated 6/26/25 was 5/15. A score of 5 means the person's cognition is severely impaired. R39's Minimum Data Set (MDS) Section GG dated 6/18/25 revealed that R39 required assistance to perform most of the Activities of Daily Living (ADLs), particularly incontinence care, toileting, bed mobility, and transfers.On 9/24/25 at 1:08 PM, an interview with the Social Service staff (Staff CC) was conducted. The Staff CC confirmed that R39 enrolled in hospice care services on 9/19/25. When Staff CC was asked why R39 was not coded in the 802, it reflected R39's hospice status. Staff CC indicated it was the MDS Nurse's responsibility to make changes in the CMS-802 Form. Staff CC explained she sends the referral to the Hospice agency via email, and usually the rest is taken care of by the facility. She does not follow up with the rest. Staff CC verified that there was no hospice agreement, no initial hospice evaluation or care guide in the EMR, and no hospice visit notes or schedule for hospice care were found in R39's current record. The Administrator admitted that it was an error on their part and that #39 was enrolled in hospice care on 9/19/25. When queried on what happened to the assessments, visitation notes, and the enrollment form from hospice?During the survey on 9/23/25 until 09/25/2025 at 1:36 PM, R39's clinical record was reviewed. It was verified and validated that no hospice agreement/contract in Resident#39, the EMR (Electronic Medical Record), no initial assessment/Hospice evaluation, no hospice progress notes, and no record of care services provided for R39 was found. There was no schedule of hospice visits by the nurse, hospice aide, or chaplain. Confirmed by the social services (Staff CC) on 09/24/25 at 1:08 PM, the Staff CC revealed that the hospice record would be found in the Electronic Medical Record (EMR). That's the only place to put the hospice visits, assessment, and the enrollment packet. On September 25, 2025, at 1:40 PM, the Director of Nursing (DON) was queried about why there are no hospice contract agreement notes scanned or recorded in the resident's file. The DON said to the surveyor, I will find out for you. On 9/25/25 at 1:40 PM, after R39's record review, no hospice service notes, no hospice plan of care and services from the hospice agency, and no schedule of hospice visits were found on record.On 9/25/25, the surveyor requested a facility binder for all residents listed as receiving hospice care services but was reminded by a staff member that they don't keep a hospice binder or post a hospice calendar. Everything is electronically scanned or entered in each of the residents' records. An attempt to verify with the Facility Minimum Data Set (MDS) staff on 9/26/25 at 1:30 PM. No Facility MDS was available to query regarding the error in coding R39 as hospice in Form 802. The Fcility MDS staff were available to explain why R39 was not accurately coded as receiving Hospice Care.On 9/26/25 at 12:04 PM, a call was made to the Hospice Agency to verify the absence of a contract on file, as well as the lack of progress notes and a service record in R39's chart. However, there was no reply at the time the survey exited.The Administrator validated on 9/26/25 at 11:00 AM that it was an error on their part and that R39 was enrolled in hospice care on 9/19/25. When queried, what happened to the assessments, visitation notes, and the (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enrollment form from hospice? It was not in R39's clinical record in the EMR, but the surveyors were assured that all the hospice visits and progress notes had been scanned and entered on 9/26/26 at 11:30 AM, including the signed Hospice Agreement.All of R39's hospice visit notes dated 9/19/25, 9/20/25, 9/22/25, 9/23/25, 9/24/25, and 9/25//25 were scanned and uploaded into R39's EMR on 9/26/25 at approximately 11:30 AM, The Administrator notified the surveyor that the Hospice Service Agreement dated 9/19/25 was scanned and uploaded, along with other pertinent hospice visit notes.The Palliative/ End of Care Policy was reviewed on 9/26/25 at 1:45 PM. It specified: . The physician will order a hospice evaluation as indicated: for example , by resident or family request. If hospice becomes involved in the care of the resident:a. The facility and hospice will establish a coordinated plan of care that reflects and supports the hospice policy,b. The plan of care will include directives for managing pain and will be revised and updated as the resident's status changes.c. The facility and hospice will identify the specific services that will be provided by each entity, and this information will be communicated in the plan of care.d. The hospice retains overall responsibility for directing and coordinating the plan of care related to the terminal illnesses and related conditions f. The hospice and facility will communicate with each other when any changes are indicated or made to the plan of care .5 Nursing staff will implement comfort measures identified in the comprehensive care plan .