STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235175	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Frankenmuth	500 West Genesee Frankenmuth, MI 48734

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings include: On 05/04/2026 at 8:54am during the initial kitchen tour, observed yogurt with a best by date of April 22nd, 2026, in the walk-in cooler. On 05/04/2026 at 9:00am, milk with a use by date of 5/3/26 was observed in the three-door fridge. During this observation, when asked how long milk is kept for, Certified Dietary Manager (CDM) R stated it's good for seven days once opened. According to the 2022 Food Code, 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.On 05/04/2026 at 9:08am, the coffee machine was observed visibly soiled on the siding of the machine near the nozzles and mineralization build up was observed inside the nozzles. On 05/04/2026 at 9:12am, the mixer was observed visibly soiled on the interior ceiling of the mixer and reddish residue was observed inside the bowl. During this observation, when asked how often the mixer is cleaned, CDM R stated it's cleaned before and after it is used. On 05/04/2026 at 9:16am observed the ice machine filter dated 8/24/23 and cups laying on the floor behind the ice machine in the nourishment room. On 05/04/2026 at 9:20am, a brown splotch was observed on the interior wall of ice machine. During this observation, when asked how often the ice machine is cleaned, Maintenance Director (MD) S stated it's cleaned every month. When asked how often the ice machine filter is replaced, MD S stated it needs to be done now and that it's usually changed every year. According to the FDA 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 05/04/2026 at 9:26am cut watermelon was observed without datemarking in the fridge of the memory care unit. According to the 2022 Food Code, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.According to the facility's policy on datemarking, All foods stored in the refrigerator or freezer will be covered, labeled and dated (opened on and "use by date).On 05/04/2026 at 11:55am during lunch observation, boiled egg on salad was temped at 54 F and ranch at 53 F, sitting on a cart behind the steam table without ice. During this observation, CDM R was interviewed on what temperature food should be cold holding, and stated it should be at 40-41 F. On 05/04/2026 at 12:03pm observed [NAME] T go to fridge, then back to the prep area, and gloved one hand without washing hands. On 05/04/2026 at 12:11pm, cut tomato sitting in a container at the prep sink was temped at 65 F. On 05/04/2026 at 12:12pm cream of mushroom was temped at 75 F and was sitting out of its original container near the prep sink. During this (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observation CDM R stated the cream of mushroom should be refrigerated after opening. According to the FDA 2022 Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control, time/temperature control for safety food shall be maintained: .at 5 C (41 F) or less.On 05/04/2026 at 12:24pm CDM R was interviewed on when hands should be washed when gloving hands, CDM R stated staff are supposed to wash their hands before gloving. According to the 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms.immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and.Before donning gloves to initiate a task that involves working with food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility 1) Failed to 1) follow enhanced barrier precautions (EBP) for residents identified with qualifying medical needs, for one resident #6 (R6) of one resident; 2) Ensure that respiratory treatment and suctioning equipment were properly stored and maintained, for one (R6) of one residents; 3) Ensure that infection control rounding data collection and surveillance was performed for all residents residing in the facility; and 4) Ensure that appropriate glucometer disinfection was followed for one of three residents reviewed (Resident #29) for infection prevention. Findings include: Observation and interview on 05/04/2026 at 10:36 AM surveyor knocked and walked into nurses providing high contact direct care to resident #8. Observed Resident #8 to be lying on his back with his brief down with foley catheter care with was cloth, abdominal peg tube site dressing being placed, and loose gray liquid stool noted on brief. The Unit manager Registered Nurse (RN) O, Licensed Practical Nurse (LPN) E and Licensed Practical Nurse (LPN) P were providing direct high contact care with no gowns, or mask worn. Observation of Resident #8's buttocks with LPN E and RN O revealed moisture associate skin damage with gray loose/liquid stool. RN O stated that staff are putting barrier cream on cracked skin areas, observed bleeding from multiple fissures/cracked in the skin, sloughing of the skin noted. On 05/04/2026 at 10:39 AM Licensed Practical Nurse P came into the room to assist with the cleaning of resident's bowel movement, loose, due to being on tube feeding. Resident was rolled to right side and did not wake up or have any change in cognition noted. Resident #8 remained Lethargic and non-responsive to his name. Not one of the staff members wore enhanced barrier precautions while attending to the resident with foley catheter, tube feeding, and multiple open areas on the buttocks noted. Infection Control Task: Observation and interview on 05/06/2026 at 11:50 AM Licensed Practical Nurse (LPN) Infection Preventionist (IP) N about facility wide round for surveillance Rounding, IP N stated that she began at the facility only 60 days prior to survey. Observation of the IP N office space revealed binders and desktop computer. Record review of the January 2026 rounding request data revealed a search of the infection control office area by IP N for rounding audits/data located a purple binder, Records review of the purple binder data from August 2025 through February 2026: August 2025-review of the surveillance binder noted there were no kitchen, medication rooms, dining rooms and therapy gym, resident rooms, or enhanced barrier precaution rooms rounding/audit of rounding surveillance documentation or analysis found. September 2025- review of the surveillance binder noted there were no kitchen/laundry rounding/audit, no medication room rounding/audit, no dining room rounding/audit or therapy room, resident rooms, or enhanced barrier precautions rounding/audit found. October 2025- Record review of the surveillance binder noted there were only: injection safety audit, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/06/2026, at 2:53 PM, Nurse L was asked what they used to clean the glucose meter and Nurse L offered, an alcohol swab. Nurse L was asked if that's how they normally clean it and Nurse L stated, why, am I not supposed to?. Nurse L was asked if the facility instructed them on how to disinfect a glucose meter and Nurse L stated, yeah with a purple top. On 5/06/2026, at 12:32 PM, the Director of Nursing (DON) was asked how the facility disinfects blood glucose meters and the DON offered, they're supposed to use a purple top. R6A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R6 was admitted to the facility on [DATE] with diagnoses: stroke, aphasia (cognitive communication deficient with speech and understanding), tracheostomy (artificial patent airway), percutaneous endoscopic gastrostomy tubes (PEG / delivers nutrition and medications directly into the stomach), epilepsy (seizure disorder), muscle weakness, right above the knee amputation (AKA). The MDS assessment dated [DATE] indicated the resident had severely impaired cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 0/15 and was dependent on assistance for care. On 05/04/2026 at 09:50AM, an observation of an EBP sign outside R6 door was made. An observation of R6 resting in bed with eyes closed, R6 had a dressed tracheostomy humidified with O2 set at 4L. A suction canister was sitting on the nightstand, canister had ~ (approximately) 200cc's of straw yellow drainage and was hooked up to tubing neither dated, the open end of the suction tubing was resting inside of a garbage can with visible trash and debris in the can. R6's call light was hung over the headboard of the bed and out of reach of the resident. There was a nebulizer mask hooked to the machine sitting in open air on the resident's bedside table. Hospice CNA A was present in the room and provided care to R6's roommate, she was asked to verify the location of the call light and condition of the suction canister, tubing and Nebulizer mask. Hospice CNA A confirmed that and said that it was not sanitary, she also verified that the resident call light was not with in his reach. According to a record review of the facilities procedure labelled Small volume nebulizer it was revealed: Purpose: small volume nebulizers convert liquid medications into a fine mist, allowing for delivery of the medication deep into the lungs. Appropriate cleaning and storage techniques of small volume nebulizers decrease the risk of introducing bacteria into the and reduces potential pulmonary infections. and Cleaning:1. Twist open the nebulizer cup and dump out any residual remaining from treatment. 2. Rinse nebulizer cup and components with water. 3. Allow the nebulizer cup and components to air dry on a clean absorbent towel. 4. Once dry store the nebulizer cup and mouthpiece in a bag and label. 5. Replace nebulizer hand tubing weekly per procedure. According to a record review of the facilities policy labelled Tracheostomy care it was revealed: Policy: facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice. and indicated that suctioning was a sterile technique, it did not include guidelines on equipment dating or storage. On 05/05/2026 at 08:50AM, an observation of R6 resting in bed with eyes closed, R6 had a dressed tracheostomy humidified with O2 set at 4L. A suction canister dated 5/4 was sitting on the nightstand, canister had ~ (approximately) 500cc's of straw yellow drainage and was hooked up the suction tubing was coiled on the nightstand with the open end of the suction hub was resting uncovered on the nightstand. There was a deconstructed nebulizer chamber with components and mask on the bedside table resting on a brown paper towel, no moisture was seen on equipment nor paper towel. On 05/05/2026 at 09:25AM, During an interview with Nurse B she was asked about suction and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	respiratory equipment storage and care for infection control, she said that nebulizers, masks and suction equipment not in use should be stored dry and clean in a container of bag and labeled/dated. When she was asked to return to R6's room to observe the equipment she said she was unable to at that time. On 05/05/2026 at 09:33AM, OT G was asked to observe R6's nebulizer and suction equipment, OT G observed R6 room and verified the nebulizer was dry and on the bedside table and the suction tubing was attached to the canister (with straw colored drainage accumulated) and open end of suction was coiled and, on the nightstand, uncovered. OT G said that does not seem correct and stated, I do not know for sure. On 05/05/2026 at 12:15PM, an observation of R6's deconstructed nebulizer chamber with components and mask remain in the same location as observation at 08:50Am and are dry and not stored. On 05/05/2026 at 12:45PM, during a follow up interview with Nurse B she said saw the condition of the equipment brought to her awareness earlier and that she had fixed it, she said she had changed R6's suction canister and tubing and stored it in a bag and labelled and dated it all. Nurse B was asked about the nebulizer being out and not stored she said it was ok if it was drying, when asked how long it takes to dry she did not have and answer why it had been dry and out since 08:50AM. Nurse placed then stored it in a plastic bag and placed in the plastic tub at the residents bedside. According to a record review of the facilities policy labelled Infection prevention and control program it was revealed: Policy: the facility has established and maintains an infraction control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of based transmission of communicable diseases and infection as per accepted national standards and guidelines. And 11. Supplies protocol: b. Sterile supplies are routinely checked for expiration dates and are replaced as necessary. d. Nonsterile supplies are stored and maintained as clean prior to use. On 05/06/2026 at 09:00AM, knocked on door and entered the room of R6, observation of R6 privacy curtain tucked behind the tube feed pole and open to roommate / door to hall side, the window on the other side of resident had the curtain open to the outside while CNA D completed a brief change for R6. CNA D was wearing gloves and no other PPE, she touched the linens, trash cans and removed her gloves with no hand hygiene and repositioned the resident in the bed. CNA D asked if the curtains should be closed for privacy with brief changing and care and she said yes, when she was asked if there were closed, she did not answer but gave a blank look. CNA D was asked if she needed to wear any PPE with personal care for R6 since he was in EBP and she stated, oh yes, I forgot. On 05/06/2026 at 11:31AM, during an interview with ICP Nurse she was queried about storage of suction and respiratory equipment, and she verified it should be stored clean when not in use. She was asked about EBP residents and high contact care, and she verified that regardless of why a resident is in EBP that dressing, toileting, bathing and brief changes were all considered high contact activities and required PPE to be used by staff. According to a record review of R6's care plan: Focus: (R6) requires enhanced barrier precautions related to trach, peg placement with Interventions: Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray; Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis). And Focus: Resident has an impaired pulmonary/respiratory status related to tracheostomy with Interventions: Suction per orders and as (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	needed; Treatments as ordered; Oxygen as ordered. According to a record review of the facilities policy labelled Enhanced barrier precautions it was revealed: Policy: it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi drug resistant organisms. With Definition: enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multi resistant organisms that employ targeted gown and glove use during high contact resident care activities. and . Guidelines: 3. Implementation. b. PPE for EBP is only necessary when performing high contact activities. 4. High contact resident care activities. include: a. dressing; d. providing personal hygiene; f. changing briefs.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain cleanliness and ensure that appropriate backflow prevention was installed at plumbing fixtures, resulting in the potential for the spread of pathogens and contamination to the water supply, affecting all residents. Findings include:On 05/04/2026 at 2:12pm the hand sink near the washers in the laundry room was observed without a sewer line. The wastewater was observed going directly into a trash bin below sink. The trash bin below the hand sink was approximately half full of wastewater. During this observation, when asked how long the sink has been broken, Housekeeping Manager U stated for about two months, and that they empty the trash can into the mop bucket sink. On 05/04/2026 at 2:18pm observed a utility sink without an atmospheric vacuum breaker (AVB), with an attached hose and a chemical feeder downstream, in the housekeeping closet on the east hall. On 05/04/2026 at 2:21pm observed a chemical feed downstream of an AVB on the utility sink in the housekeeping closet on main hall. On 05/04/2026 at 2:22pm observed a chemical feed downstream of an AVB in the housekeeping closet in central hallway. On 05/04/2026 at 2:27pm observed a chemical feed downstream of an AVB on the utility sink in the housekeeping closet on west hall. On 05/04/2026 at 2:28pm observed a soiled towel on the floor of the shower area in the shower room in west hall. According to the State of Michigan's 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve).According to the State of Michigan's 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents were treated in a respectful and dignified manner to ensure timely assistance with care, that call lights were in reach, privacy and a homelike environment for a Confidential Group of Residents and Residents #6, #17, #67, and #83 from a sample of 41 residents reviewed. Findings Include: Confidential Group of Residents On 5/05/2026 at 11:01 AM, during an interview with a Confidential Group of Residents they verbalized their frustration with staff entering their rooms to answer call lights and then the staff say they will be back, shut off the call lights and leave and don't come back. The Confidential residents said, Why don't they take care of our needs while they are there; sometimes they will not be back at all if you complain about it. During the interview on 5/5/2026 at 11:12 AM, the Confidential Group of Residents said, Sometimes the (meal) trays are late. The food is cold, including grilled cheese. One Confidential Resident said they received 2 hamburgers ice cold and when they told the staff about it they were laughed at. During the same interview, another Confidential Resident said they were awakened at 4:30 AM in the morning by a doctor working on their toenails. The Confidential Group of Residents said they had heard a few staff say some words that Weren't very nice. Several of the Confidential Residents said they heard what sounded like parties at the nurses desk in the evenings, at night and on the weekends when the management staff were not in the building. The Residents said, Staff go out for food and then more staff go out and bring in more at the nurses desk. The Confidential Group was frustrated because they were having issues with staff laughing about their cold food and waiting for care, while they brought in food for themselves. On 5/06/2026 at 1:13 PM, during an interview with the Director of Nursing/DON, the Confidential Group of residents' issues related to dignity, how they were spoken to and treated by some staff including staff saying not very nice words and not answering their call lights was reviewed. The DON said that was not Ok. Reviewed with the DON the residents' issues with staff congregating at the nurses desk and being very loud on 2nd and 3rd shifts and she said they would be addressing that. Reviewed the food concerns had been reviewed with the Registered Dietitian/RD, but the staff laughing at the residents was very upsetting to them. The DON said the staff should not be acting like that. A resident being awakened in the night for the Podiatry care was reviewed with the DON and she said she would check on what time the Podiatrist came in. A review of the facility policy titled Promoting/Maintaining Resident Dignity, date implemented 10/30/2020 and reviewed/revised 10/26/2023 provided, Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. When interacting with a resident, pay attention to the resident as an individual. Respond to requests for assistance in a timely manner. Staff members do not talk to each other while performing a task for the resident as if (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident is not there. Speak respectfully to residents. Respect the residents living space. R6 A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R6 was admitted to the facility on [DATE] with diagnoses: stroke, aphasia (cognitive communication deficient with speech and understanding), tracheostomy (artificial patent airway), percutaneous endoscopic gastrostomy tubes (PEG / delivers nutrition and medications directly into the stomach), epilepsy (seizure disorder), muscle weakness, right above the knee amputation (AKA). The MDS assessment dated [DATE] indicated the resident had severely impaired cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 0/15 and was dependent on assistance for care. On 05/04/2026 at 09:50AM, an observation was made of R6's call light hung over the headboard of the bed and out of reach of the resident. Hospice CNA A was present, she was asked to verify the location of the call light and Hospice CNA A verified that the resident call light was not within R6's reach. Hospice CNA A verified R6 was not verbal and relied on the call light to get help. There was a putty knife with sticky debris on the blade on R6's beside table, Hospice CNA A said she believed it was left by maintenance and said they had been scrapping the floor in the room earlier. A record review of R6's care plan revealed: Focus: (R6) is at risk for falls/injury related to other nontraumatic intracerebral hemorrhage, epilepsy, seizures, osteogenesis imperfecta with Interventions: Encourage resident to keep needed items within reach; Encourage resident to use call light. Focus: (R6) has an impaired musculoskeletal status related to osteogenesis imperfecta, acquired absence of right leg above knee with Interventions: Encourage resident to ask for assistance when needed. Focus: (R6) has an ADL self-care performance deficit related to cva (stoke), peg placement with Interventions: bed mobility: 2 person assist; toileting: 2 person assist; Encourage resident to use call light when assistance is needed. On 05/06/2026 at 09:00AM, knocked on the door and entered the room of R6, an observation of R6 privacy curtain tucked behind the tube feed pole and open to roommate / door to hall side, the window on the other side of resident had the curtain open to the outside while CNA D completed a brief change for R6. CNA D was asked if the curtains should be closed for privacy with brief changing and care and she said yes, when she was asked if there were closed, she did not answer but gave a blank look. According to a record review of the facility policy labelled promoting and maintaining resident dignity the Policy: it is the practice of this facility to protect and promote residents rights and treat each resident with respect and dignity. with Guidelines: 1. All staff members involved in providing care to residents (are) to promote and maintain resident dignity and respect residents rights; 12. Maintain resident privacy. R83 A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R83 was (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility on [DATE] with diagnoses: progressive multiple sclerosis (effects the central nervous system), quadriplegia (numbness / paralysis of 4 limbs), encephalopathy and depression. The MDS assessment dated [DATE] indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15 and required assistance with care. On 05/04/2026 at 09:45AM, During an interview with R83 she said she is dependent on care from staff because she was unable to walk. R83 said she had long call wait times of 30 minutes or more, explained it was especially long waits on 2nd and 3rd shifts. R83 said that last week she requested assistance from a CNA because she needed her brief changed due to having had a bowel movement and that the CNA turned off her light left her room and no one came to change her for several hours when she again requested assistance from 3rd shift. R83 expressed that she felt embarrassment from sitting in a dirty and malodourous brief that long. On 05/05/2026 at 09:20AM, during an interview with Nurse E she was asked about the call light system operations, she said that there was no centralized area that notified when a call light was triggered, that the call light are a light outside the residents room that lights up when triggered and a faint tone when from the bed side. Nurse E said that the light is red and a louder tone if it is triggered from a restroom. Nurse E acknowledged that the nurse's station was not located with clear site down each resident's hall and that if staff were not on the unit there was no central location to check for call lights. When asked about R83 complaint Nurse E said she could not account for response times on other shifts when asked. A record review of R83's care plan revealed: Focus: (R6) has an ADL self-care performance deficit related to multiple sclerosis, quadriplegia. with Interventions: ambulation: non ambulatory; bed mobility: 2 person assist with b/l (bilateral) assist bars for increased mobility; toileting: 2 person assist; transfers: (R86) will need 2 person assist and use of full mechanical lift.; Encourage resident to use call light when assistance is needed. According to a record review of the facility policy labelled promoting and maintaining resident dignity the Policy: it is the practice of this facility to protect and promote residents rights and treat each resident with respect and dignity. with Guidelines: 1. All staff members involved in providing care to residents (are) to promote and maintain resident dignity and respect residents rights; 6. Respond to request for assistance with in a timely manner. Resident #17 On 5/04/2026, at 11:17 AM, During a foot skin observation, Resident #17 was noted to pull at their chin whiskers throughout the assessment. Resident #17 was asked if they were ok with their facial whiskers and the resident quickly responded, no, I have a razor somewhere. A review of the Task list for Bathing: Monday and Thursday Evening Shift Look Back . revealed the following showers were provided: 4/6/2026 4/9/2026 4/13/2026 4/20/2026 4/23/2026 4/30/2026 5/4/2026 The column Patient Refused was not checked marked for the missed showers on 4/16/2026 and 4/27/2026. A review of the progress notes revealed no explanation as to why the resident wasn't provided their (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers. On 5/05/2026, at 1:30 PM, a record review of Resident #17's electronic medical record revealed an admission on [DATE] with diagnoses that included Hypertension, Heart attack and congestive heart failure. Resident #17 required assistance with activities of daily living and had intact cognition. Resident #67 On 5/06/2026, at 9:18 AM, During medication administration for Resident #67, Nurse J administered Resident #67's morphine after great encouragement to the resident. Nurse J stated to the resident, thank you (Resident #67) Jesus Christ with a smile on their face. Upon exit of Resident #67's room, Nurse J was asked if they normally say that to residents and Nurse J stated, yeah.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review, the facility failed to ensure that HS (evening/nighttime) snacks were provided on a regular basis for a Confidential Group of Residents, resulting in residents verbalizing feelings of anger, and frustration. Findings Include: On 5/05/2026 at 11:01 AM, during a meeting with a Confidential Group of Residents, they said they were upset about the process for receiving a snack in the evening at bedtime. They said you had to fill out a blue form, that came on their meal tray, but you had to have the form returned to the kitchen by 2:00 PM or you didn't get a snack. The residents said they did not like this process, because you could change your mind about what you wanted or they might not have what you chose if someone else took it, also some of the resident's could not ask for or fill out the form. Some of the residents said they did not receive a snack. They said if you didn't fill out the form, you did not receive one. Some of the residents said they were upset that they observed staff taking snacks for themselves and then they didn't receive one. On 5/5/2026 at 2:30 PM, during an interview with the Registered Dietitian/RD Q she was asked if the residents received an evening/HS (nighttime) snack. She said if the residents wanted a specific snack, they could fill out a blue form that came on their meal tray titled, Please Select a Snack for Tonight. There were a variety of options on the form and the form stated, Please circle 1 or 2 items only. This slip must be turned into the kitchen by 2pm to be able to honor your request. The RD said there was a snack cart that was filled by the kitchen staff and then the clinical staff, usually a nurse aide would distribute the snacks from the cart to the residents. The RD was asked about the blue form; what if the resident couldn't fill it out, or if they couldn't say what they wanted? The RD said the staff could offer the resident a snack. The RD was asked if residents could change their mind about which snack they wanted and she said they could, but the snack might not be available. Discussed with the RD Q that some residents said staff were observed taking snacks from the carts for themselves and then the residents had less options, less to choose from. She said the facility would look at their process to try to ensure the residents received a snack if they wanted one. On 5/06/2026 at 1:13 PM, the Director of Nursing/DON was asked about the process for Residents to receive an HS snack. She said she was newer to the facility and not familiar with their process. The blue form was shown to the DON, and she said she had a problem with having to fill out a blue sheet by 2pm to receive a snack. She said they would work on that.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to follow the antibiotic stewardship program and standards of practice for 4 residents (#4, #18, #40, #59) of 4 residents reviewed, for antibiotic usage, resulting in four residents receiving antibiotics without appropriate clinical rationale. Findings include: Record review of the facility 'Antibiotic Stewardship Program' policy dated 12/13/2023 revealed the purpose of the program was to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . Laboratory testing shall be in accordance with current standards of practice . The facility uses the McGreer criteria to define infections .Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made . Records review and interview on 05/06/2026 at 11:50 AM Licensed Practical Nurse (LPN) Infection Preventionist N of the antibiotic stewardship ship program: Record review of monthly Infection Tracking forms for January 2026 through April 2026 were reviewed with Infection Preventionist N:January 2026 line listing revealed that Resident #18 1/27/2026 through 2/3/2026 was started on Macrobid antibiotic for a facility acquired urinary tract infection (UTI) that did not meet the McGeer's criteria. The Infection Preventionist (IP) N could not locate a culture or organism that was to be treated. The IP N stated that there was no culture or Urine Analysis (UA) done and may have been a dip sticked urine test and decided to treat off that. The IP N could not produce a policy for urine dip stick testing or documentation of dip stick results. Record review of Resident #4 January line listing noted on 1/27/2026 through 2/5/2026, the resident #4 received Cipro antibiotic for urinary tract infection (UTI) that did not meet the McGeer's criteria. The IP N stated that the resident was re-admitted with antibiotic and no culture or UA was found, and when admitted the former IP should have gotten the cultures/lab results for documentation. Record review of the February 2026 Infection Tracking Form Revealed:Record review of Resident #59's February line listing noted facility acquired urinary tract infection (UTI) and received levofloxacin from 2/26/2026 through 3/5/2026 that did not meet the McGeer's criteria. The IP N looked for data and stated that no culture or Urine analysis for organisms was found. Record review of Resident #40's February line listing noted facility acquired urinary tract infection (UTI) and received Bactrim DS antibiotic from 2/6/26 through 2/8/26, that did not meet McGeer's criteria. Again, the IP N looked for data and stated that no culture or Urine analysis for organism was found. During the antibiotic stewardship task, the state surveyor Requested urine dip stick policy and procedure. The Infection Preventionist (IP) N stated that there is no policy or procedure that she could locate. The state surveyor requested the McGeer's policy or procedure that the facility would follow regarding infection criteria and the IP N stated that the McGeer's infection criteria is done by the infection control computer program automatically tells us if the symptoms meet or do not meet the McGeer's criteria, we don't stop the antibiotics we tell the nurse practitioner and she decides if we stop the antibiotics.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility to follow standards of practice during medication administration for three of three residents reviewed (Resident #3, Resident #28, Resident #43) along with a confidential group of residents, resulting in resident complaints of not getting their medications correctly. Findings include: On 5/05/2026, at 8:29 AM, Nurse K was standing at the medication cart outside room five. There were two medication cups filled with medications. Nurse K picked up both medication cups; 1 in their left hand and the other in their right hand. Nurse K entered room five and handed the cup from their right hand of medications to Resident #28 (Bed 1). As Resident #28 took the medications one fell and Nurse K picked up the pill and placed it into the used medication cup. Nurse K then walked to Resident #43 (bed 2) who was struggling to get their oxygen tubing adjusted into their nose. Nurse placed Bed 2's full medication cup into the used medication cup from Bed 1 (that housed the dirty pill), donned gloves and assisted Resident #43 (Bed 2) with their oxygen. Nurse K then pulled the full medication cup out of the dirty medication and handed them to Resident #43 who consumed them. Nurse K then left out of the room, threw the dropped pill into the drug buster bottle and got a new blood pressure pill for Resident #28. Resident #3: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Amyotrophic Lateral Sclerosis/ALS, dysphagia (difficulty swallowing), need for a feeding tube, COPD, diabetes, sleep apnea, heart disease, GERD and PTSD. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed some assistance with all care. A review of an Acute Care Note dated 4/26/2026 at 12:38 PM identified, .recurrent PEG tube clogging was managed without tube replacement. he continued active medications for ALS, COPD, diabetes, and other chronic conditions. On 5/04/2026 at 9:39 AM, Resident #3 was observed lying in his bed, awake and talkative. He said sometimes he did not receive all of his medications. He said sometimes during his medication administration via a peg tube/feeding tube into his stomach, medication squirted out and he didn't receive all of it. He said he really worried about that because he needed his medication and when that happened they didn't replace the medication. A review of the Care Plans for Resident #3 indicated Care Plans for Heart disease, decreased fluid intake, diabetes, gastric reflux disease/GERD, bowel and bladder incontinence, impaired mood, pain, COPD, sleep apnea, and risk for impaired skin integrity. Each Care Plan contained an intervention to Administer medications as ordered. A Confidential Group of Residents: On 5/5/2026 at 11:20 AM, during a meeting with a Confidential Group of Residents, several residents (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the nurses left the residents' medications in a cup at the bedside and then the nurse exited the room before the resident took them. One resident said there were times medications were left in a cup in the room while they were in the bathroom; the nurse was not present when the resident took the medications. One Confidential Resident said there were a few times the nurse forgot to give them their medication and the resident stated, So I went and said something about it.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 2992230. Based on observation, interview and record review, the facility failed to provide timely assistance with activities of daily living (ADL) including grooming and shaving for 2 residents (#9 and #12), of 2 residents reviewed for ADLs. Findings Include: Resident #9: Observation and interview on 05/04/2026 at 9:42 AM of Resident #9 was observed outside in the courtyard noted with chin whiskers of gray and black in color visible. Resident #9 stated that staff only shave her on shower days and would like it more often. Observation on 05/05/2026 at 11:52 AM of Resident #9 with whiskers today. seated in dining room. Observation on 05/05/2026 at 12:59 PM of Resident #9 and a visitor to go into the courtyard to sit in the sun outside. Resident chin Whiskers were visible again. Observation on 05/06/2026 at 9:57 AM of Resident #9 was observed up in wheelchair in the hallway with chin whiskers visible. Resident #12: A review of the medical record indicated Resident #12 was admitted to the facility on [DATE] with diagnoses: Dementia, PTSD, back pain, diabetes, and depression. The Minimum Data Set/MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 3/15. Section E: Behavior of the MDS assessment indicated the resident had no behaviors during the assessment look back period. Section GG of the MDS indicated the resident needed supervision or touch assistance with hygiene tasks including shaving. On 5/04/2026 at 11:09 AM, during a tour of the Dementia unit, Resident #12 was observed unshaven with whiskers approximately 1/2 to 1 inch long and sleeping at an activities table in the day room. On 5/5/26 at 10:00 AM, Resident #12 was observed in the day room in the Dementia unit, unshaven. On 5/06/2026 at 10:35 AM, Resident #12 was observed in the day room, sitting at one of the tables; his was breakfast finished. The activities staff were present, and the resident continued to be unshaven. On 5/06/2026 at 10:45 AM, the day room on the Dementia Unit was observed with Unit Manager M. Observed all male residents, approximately 6 residents but one, were unshaven: this included Resident #12. The Unit Manager/UM M was asked about this and said she did not know why they were not shaved. She said if they refused to be shaved the Nurse Aides would chart their refusal when they charted their showers. A review of the Care Plans for Resident #12 revealed: (Resident #12) has an ADL (activities of daily living) self-care performance deficit related to generalized weakness and deconditioning, date initiated 12/17/2024 and revised 3/20/2025 with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions including: (Resident #12) showers Monday and Thursday evening, date initiated 1/25/2025 and revised 11/11/2025; Bathing: 1 person assist, date initiated 12/19/2024 and revised 3/20/2025. There was no mention of assisting the resident with shaving or that the resident refused shaving. A review of the Tasks: Behavior Symptoms charting from April 7, 2026, to May 6, 2026 revealed the resident had a few behaviors of repetitive movements and wandering. The remainder of the charting said, None of the above observed. There was no aggressive behaviors or rejection of care. A review of the Tasks: Bathing Monday and Thursday Evening shift documentation from 4/9/2026 to 5/4/2026 revealed the resident missed one bath/shower on 4/13/2026. There was no indication that the resident refused to be shaved. A review of the facility policy titled, Activities of Daily Living (ADL's), date implemented 10/30/2020 and revised 12/28/2023 provided, The facility takes measures to minimize the loss of resident's functional abilities, including activities of daily living (ADLs). Activities of Daily Living include the ability to: 1. Bathe, dress, and groom. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to date dressings and give consistent dressing changes for 2 residents (Resident #1, Resident #17) of 3 residents reviewed for wound care, resulting in prolonged healing. Findings include: Resident #1: In an interview on 05/04/2026 at 9:28 AM with Resident #1 was lying in bed with a sheet covering him. Resident #1 was not sure if he came with the coccyx wounds or got them at facility, he believes at hospital. Observed air mattress in place. The resident stated that the treatments/dressings are not always done every day, and he does not know why, the wounds seem to be getting bigger to him. He declined to have surveyor look at his wounds. Surveyor will request wound care nurse dressing change. Record review of Resident #1's medical record revealed he is his own responsible party, Brief Interview of Mental status (BIM's) score of 13 out of 15, some cognitive impairment, will check the MAR TAR records for consistency of dressing change/treatments. Record review of treatment administration record for January through May 2026 revealed missing documentation of treats provided or performed and signed out by the nursing staff. January 2026- 3 missed treatments to the coccyx, 3 missed treatments to left gluteal. February 2026- 3 missed treatments to the coccyx, 3 missed treatments to left gluteal. March 2026- 6 missed treatments to the coccyx, 6 missed treatments to left gluteal. April 2026- 3 missed treatments to the sacrum, 3 missed treatments to left gluteal. Observation and interview on 05/06/2026 at 10:59 AM licensed Practical Nurse (LPN) wound care C of Resident #1's room and dressings. Observation on 05/06/2026 at 11:03 AM Observed pressure wearing boots when in bed, Resident stated that the boots get hot and sweaty he did not want them on, declined a pillow to elevate the feet also. LPN C stated that the resident's Coccyx wound he does not like to be off his bottom, we had a conversation that I educated again to get off his coccyx to offload, Resident #1 at present declined to offload or shift position. Residents left lateral leg abrasion, he declined soft boots and pillow he stated no. Left gluteal- facility acquired, we have an unavoidable form for him. The Resident signed on to hospice recently and has human immunodeficiency virus. LPN C stated that she did not understand the skin and wound tab, in the computer program. LPN C started in December at the facility. Resident #1 is his own person, and he is non-compliant with his care/positioning, after his last hospital admission he came back with worsening of wounds. In an interview and records review on 05/06/2026 at 1:14 PM with the Director of nursing (DON) about the skin/wound treatments on the Treatment Administration Records (TAR). Record review of Resident #1's Medication Administration Record (MAR) and Treatment Administration Records (TAR) the DON stated that she was aware there are blanks on the MARs and TARs with blank spots. The (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON did not know why they are blank, and there should have been a progress note if left blank. The State surveyor inquired of the chart codes/follow-up codes located at the bottom of the MAR/TARs, the DON stated that the codes chart at the bottom of the MAR/TAR forms has a documentation key for staff when resident at Hospital, refuses, Leave of Absence, the nurses are not using the key. The DON stated that the facility was trying to monitor the MAR TARs. Nurses are on 12-hour shifts, and the MAR TARs are set up for 8-hour shifts so there is a shift not accounted for. The facility is Liberal treatments and med pass but still have blank spots. Plan was to get the PCC switched to 12 shifts. But it has not happened, The DON stated that she is new to the building started March 2nd, 2026, and has a lot of work to do. On 5/04/2026, at 10:56 AM, Unit Manager (UM) , entered Resident #17's room for a skin observation of their feet. UM M removed a bandage that was covering the right great toe wound. There was no date on the bandage. The bandage appeared to be old. The inside pad of the bandage was completed saturated with dark red and black drainage that appeared old and was odorous. UM M was asked if they saw a date on the bandage and UM M stated, there's no date on it. Resident #17 stated, they had put the bandage on two days ago. On 5/05/2026, at 1:30 PM, a record review of Resident #17's electronic medical record revealed an admission on [DATE] with diagnoses that included Hypertension, Heart attack and congestive heart failure. Resident #17 required assistance with activities of daily living and had intact cognition. A review of the Treatment Administration Record 5/1/2026 – 5/31/2026 revealed a treatment order Right great toe: Cleanse with NS or wound cleanser, pat dry, apply collagen Ag and cover with foam dressing. Every day shift -Start Date- 04/29/2026 0700 – D/C Date- 05/05/2026 . On 5/06/2026, at 10:09 AM, Wound Nurse C was alerted of the observation of the undated dressing to Resident #17's right great toe wound and that the dressing appeared old.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that an Enteral nutrition (tube feeding/nutrition through a feeding tube into the stomach or intestines) formula was administered as ordered for one resident (Resident #3) and the enteral feeding equipment was properly maintained for one resident (Resident #4) of 4 residents reviewed for enteral nutrition/feeding tubes. Findings Include: Tube Feeding: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Amyotrophic Lateral Sclerosis/ALS, dysphagia (difficulty swallowing), need for a feeding tube, COPD, diabetes, sleep apnea, heart disease, GERD and PTSD. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed some assistance with all care. On 5/04/2026 at 9:24 AM, Resident #3 was observed lying in bed awake and alert. He answered and asked questions. He said he had a feeding tube, and a gauze dressing undated was observed on his abdomen at the feeding tube insertion site. The feeding tube had a darkened substance on the outside or inside of the tube near the port. Th resident said the dressing was not changed daily and was supposed to be. During the interview with Resident #3 on 5/4/2026 at 9:24 AM, when asked about the tube feeding/enteral nutrition, the resident said the staff sometimes took the tube feeding down early. He said it was supposed to run at nighttime and finish in the morning. He said sometimes the nurses did not start the tube feeding until 12:00 AM and he would not receive all of the tube feeding. Resident #3 said sometimes the bottle was not empty when they took it down. Resident #3 also said the nurses didn't always flush the tube with water properly, and sometimes it would spray him in the face. A review of the physician orders for Resident #3 provided: Nutren 2.0 @100 ml/hr (per hour) x 10 hours, Provides: 2000 kcal (calories), 80g protein, 700 ml free water, 1000 ml Total Volume, Up at 2000 (8:00 PM)- ensure volume starts at zero. Down at 0600 (6:00 AM)- Document pump volume and clear, start date 3/24/2026. On 5/05/2026 at 2:40 PM, Registered Dietitian/RD Q was interviewed about Resident #3's enteral nutrition. She said he was supposed to receive 1000 ml a day, which was one entire container of Nutrin 2.0 that contained 2000 calories of nutrition. She said the resident should receive the 1000 ml of the Nutrin and if it was not finished, the nurse should let it continue to run until it was finished. RD Q said the orders were written to clarify this to ensure the resident received the appropriate amount. The RD said she had spoken to the resident about his calorie/nutrition needs. During the interview on 5/5/2026 at 2:40 PM with the RD Q, nursing documentation of the administration of the Nutrin 2.0 tube feeding was reviewed in the electronic medical record Medication Administration Record/Treatment Administration Records (MAR/TAR) for April and May 2026. The RD said the amount administered should be documented on the MAR. On the May 2026 MAR, there were various amounts of tube feedings documented as administered: several were much less than 1000 ml (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily as ordered. The RD Q said the nurses had said in the past that they had trouble with the administration pumps for the tube feeding and they did not always work appropriately. A review of the March, April, and May 2026 MAR's with RD Q on 5/5/2026 at 2:45 PM identified the following: March 2026 MAR: 12 days were below 1000 ml; 2 days were 729 ml, 2 days were 750 and 759 ml; 9 days were over 1000 ml with one day 1529 ml and one day 1562 ml. (The order on the MAR said Up at 2000 (8:00 PM) and down at 0600 (6:00 AM) (for a total of 10 hours at 100 ml an hour = 1000 ml). April 2026 MAR: 2 days had no documentation that the resident received the tube feeding and there was no explanation why; 22 days were below 1000 ml; 4 of the 22 days was 800-900 ml; 7 days were below 800 ml with 2 days in a row exactly 746 ml. The lowest amount was 730 ml. May 2026 MAR: May 1st – 700 ml, May 2nd - 997 ml, May 3rd – 997 ml, May 4th – 2000 ml. A review of the Care Plans for Resident #3 provided: (Resident #3) has an impaired gastrointestinal status related to GERD, recent feeding tube placement, date initiated 12/17/2024 and revised 5/7/2025 with Interventions including: Diet as ordered, date initiated 12/17/2024. (Resident #3) is at risk for altered nutritional status related to ALS. date initiated 12/22/2024 and revised 4/30/2026 with Interventions including: Administer enteral nutrition per orders, date initiated 5/8/2025. On 5/5/2026 at 4:45 PM, Resident #3 and Confidential Person W were interviewed and said on 4/29/2026 the resident did not receive his tube feeding and his stomach became upset the next morning when he received his medications, she said they were worried about it because they were taking a day trip to the casino. Resident #3 confirmed there was at least one day he did not receive his tube feeding. The resident said he had spoken with the Dietitian and hoped it would be better in the future. A review of the facility policy titled, Feeding Tubes, date implemented 1/1/2021 and reviewed/revised 10/15/2024 provided, Policy: Feeding tubes will be used only as necessary to address malnutrition and dehydration, or when the resident's clinical condition deems this intervention medically necessary to maintain acceptable parameters of nutrition and hydration. A resident who is fed by enteral means receives the appropriate treatment and services. The facility will utilize the Registered Dietician in estimating and calculating a resident's daily nutritional and hydration needs. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders. Resident #4: On 5/04/2026, at 10:35 AM, Resident #4 was resting in their bed with their enteral feeding hooked to their abdomen and running. The enteral bag was dated 5/3 0200 (2:00 AM) with the initials K E written on the bag. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/04/2026, at 10:45 AM, Nurse C entered Resident #4's room and was asked what date was written on the enteral feed bag and Nurse C stated, 5/3 2AM. Nurse C offered, maybe it was a mistake as the water flush bag had the date of 5/4. Nures C was unsure if the initials K E was the nurse initials that hung the bag or possibly the residents' initials. On 5/04/2026, at 3:45 PM, Resident #4 remained in their bed with the enteral feed bag attached to their abdomen with the date of 5/3 0200. On 5/05/2026, at 3:00 PM, a record review of Resident #4's electronic medical record revealed a readmission on [DATE] with diagnoses that included Traumatic brain injury, Dysphagia with Percutaneous gastrostomy tube placement. Resident #4 required extensive assistance with all activities of daily living and had severely impaired cognition. A review of the Focus (the resident) is at risk for altered nutritional status related to NPO (nothing by mouth) with PEG tube placement . Inerventions . Provide nutritional supplements as ordered Date Initiated: 02/10/2025 . On 5/06/2026, at 12:57 PM, The Director of Nursing (DON) was alerted of Resident #4 's enteral nutrition bag observation. According to Indiana University Health, Guidelines for tube feeding expiration dates, feeding bags: replace every 24 hours to prevent bacterial buildup.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure sanitary storage of respiratory equipment for 1 resident (Resident #3) of 3 residents reviewed for respiratory care. Findings Include:Resident #3: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Amyotrophic Lateral Sclerosis/ALS, dysphagia (difficulty swallowing), need for a feeding tube, COPD, diabetes, sleep apnea, heart disease, GERD and PTSD. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed some assistance with all care. On 5/04/2026 at 9:39 AM, Resident #3 was observed lying in his bed, awake and talkative. He had a variety of oxygen equipment at the bedside including: an AVAPS (Average volume-Assured Pressure Support) machine providing oxygen used to assist in airway management/oxygenation; a cough assist machine, used to promote a cough and clear the airway and a suction machine to clear mucous secretions. Resident #3 pointed at the AVAPS machine and said he used that when sleeping. When asked about the cough assist machine, he said he used it sometimes when the staff helped him. The cough assist machine was sitting on the bedside nightstand, and the hose was observed bent at an angle and pinched in the drawer to the nightstand. The mask for the AVAPS machine was lying uncovered in a basket on the upright cart holding the AVAPS machine. It was buried beneath other items. Also observed in Resident #3's room on 5/4/2026 at 9:40 AM, were 3 one gallon jugs of distilled water. One jug sat on a shelf and was approximately 2/3 full and was not dated when opened. Two more gallon jugs were sitting on the floor, and both were empty. One had another residents name written in permanent marker on the jug. The other resident's room was across the hall from Resident #3. Neither bottle had been dated when opened. A review of the physician orders and May 2026 Medication Administration Orders/Treatment Administration Orders- MAR/TAR's for Resident #3 identified the following: Cough Assist- Ensure device is working correctly. Assist resident to use cough assist q (every) night and as needed, at bedtime, start date 3/3/2026. Cough Assist- Clean mouthpiece after use and as needed with soap and water q (every) day. Dry well, ensuring no visible moisture or water droplets remain on the equipment prior to storing Cover with a Plastic bag or completely enclosed in storage when not in use, every day shift, start date 3/3/2026. AVAPS- Clean mask cushion after use with soap and water q (every) day. Dry well, ensuring no visible moisture or water droplets remain on the equipment prior to storing. Cover with a Plastic Bag or Completely enclosed in storage when not in use, every day shift, start date 3/3/2026. On 5/04/2026 at 9:34 AM, during an interview with Nurse V, she observed the empty 1 gallon distilled water bottle with another resident's name written on it. The Nurse said it was a resident across the hall, and she did not know why it was in Resident #3's room; she said it shouldn't have been in the room and she disposed of it. On 5/06/2026 at 10:40 AM observed residents room with Nurse O, observed Resident #3's oxygen mask for the AVAP machine lying on top of the basket attached to the machine. The resident said it did not get cleaned; observed the mask was uncovered and appeared soiled. The Nurse said she would take care of the mask. Observed the cough machine and the tubing was kinked and partially shut in the bedside dresser top drawer; it was observed in the same location for 3 days. The distilled water gallon jug 2/3rds full was undated when opened, reviewed the water could grow bacteria over time; Nurse O said she would take care of it. A review of the Care Plans for Resident #3 identified the following: (Resident #3) has an impaired pulmonary/respiratory status related to COPD (chronic obstructive pulmonary disease)/Emphysema, sleep apnea and ALS, date initiated: 12/17/2024 and revised 2/6/2025. The Care Plan referenced CPAP (continuous positive airway pressure) but did not refer to the AVAP machine. There was no mention of caring for or cleaning the equipment for the AVAP machine or mask. There was no mention of the Cough Assist machine. A review of the facility policy titled, Oxygen Administration, date (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented 06/23/2025 provided, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The Resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system. Keep delivery devices in a plastic bag when not in use. Cleaning and care of equipment shall be in accordance with facility policies for such equipment.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2993831.Based on observation, interview, and record review, the facility failed to ensure that nursing staff were reviewed for competency prior to caring for residents, for one of five staff reviewed for staffing education and competency.Findings include: On 05/05/2026 at 11:41Am, an e-mail request was sent requesting performance evaluations, competencies, education, license and certificates for 5 selected staff that included Nurse J. On 05/05/2026 at 10:45 AM, An observation of Nurse J was made independently working on the dementia unit and requested her assistance with resident identification in the dining/activities room. When asked Nurse J she said she had been a nurse about 1 year and was newer to the facility. On 05/05/2026 at 1:20PM, During an interview with Human Resources (HR) J she was asked to provide education, competencies, certificates and licensure requested for the 5 selected staff that included Nurse J. On 05/06/2026 a record review of Nurse J revealed that she was hired at the facility on or around on March 11th, 2026, and was assigned skilled nursing facility (SNF) competencies, in-services and trainings on March 11th, 2026, with completion due dates of March 31st and April 10th, 2026. The record revealed Nurse J had completed 2 of the 30 competencies, in-services and trainings on March 26th, 2026, and none of the others. The 2 completed competencies were PPE donning and doffing and hand hygiene. The record revealed that 4 additional competencies, in-services and trainings were assigned to Nurse J on April 10th, 2026 with completion due date of April 30th; and on May 1st, 2026, with completion due date of May 31st, 2026. None of the additional 4 assignments were marked as completed. According to a record review of the 6AM to 6PM nurse shift assignments for May 4th 2026 that Nurse J worked independently and was not indicated as orientation; 6AM to 6PM nurse shift assignments for May 5th, 2026 that Nurse J worked independently and was not indicated as orientation; 6AM to 6PM nurse shift assignments for May 6th, 2026, that Nurse J worked independently and was not indicated as orientation. On 05/06/2026 at 10:01AM, During and interview with the DON she was asked how she ensured her staff, including nurses were competent and completed the required competencies, in-services and trainings. The DON said that from what she understood that was all done upon hire and that HR tracked that. The DON said she is new to the facility and that she had not taken part in that yet, the DON said that HR I was not at work for bereavement that day. The DON was asked if staff are allowed to be on the floor independently if they have not completed the initial competencies, in-services and training, and she said, 'they are not supposed to be'. The DON said that her staff also get assignments monthly in the SNF (computerized) training program and they have a due date to complete the competencies, in-services and trainings or they will be removed from the schedule until they complete it. The DON was asked to review the competencies, in-services and trainings that were provided by HR on 05/06/2026, After review of the documentation the DON said she was surprised by this and now, I want to check everybody's competencies, in-services and training. The DON agreed that Nurse J had worked at the facility since March of 2026 and verified she was no longer on orientation and had worked independently as a nurse. On 05/06/2026 at ~(approximately) 9AM to ~3PM, Nurse ' was observed working independently on the dementia unit. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/06/2026, at 9:24 AM, the Administrator was asked to provide competency, eligibility for hire, dementia and abuse training for Nurse J . The Administrator and DON was alerted of the observation of Nurse J with Resident #67. On 5/06/2026, at 9:49 AM, the Administrator entered the conference room to clarify the request for Nurse J's dementia/abuse training needs and stated the facility had already provided the document. On 5/06/2026, at 9:50 AM, a record review along with the Administrator of Nurse J's education document revealed that Nurse J only had completed sections for Personal Protection Equipment (PPE) and Hand Hygiene. A further review revealed General Orientation-Abuse, Neglect . Behavioral health . Dementia . Resident rights . Medication Pass . Assigned [DATE] Due [DATE] . were all not completed. The Administrator was asked to provide proof Nurse J was eligible for hire and the Administrator offered that Human Resources (HR) was out of the office and would provide it as soon as they could. On 5/07/2026, at 10:00 AM, the facility provided an updated education document for Nurse J. The document was updated to revealed Nurse J had completed the above training on 5/5/2026 which was the day prior to the record review with the administrator of the incomplete education document.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on interview and record review, the facility failed to ensure that the daily staff posting was accurate for all staff that provided care for all residents at the facility.Findings include: A record review of the facility daily staff postings revealed that it displayed CNA's, LPN/LVN and Med tech and No RN hours. It was requested for the last 2 weeks (April 21st through May 6th) be uploaded to the (computer document storage program).On 05/05/2026 at 1:20PM, during an interview with scheduler H was asked about the daily staffing posted that displayed CNA's, LPN/LVN and Med tech and No RN hours. She said she was new and that it was completed by HR. During the interview HR I entered the room and was asked about the posting and RN coverage, she said it was pulled from the (scheduling system) and maybe it was not pulling that information, She agreed that the format they posted did not show RN hours and that it was inaccurate.05/05/2026 at 3:20PM, requested copy of the posted staffing and that it be placed into (computer document storage program), 2nd request. Received paper copy of the postings. HR I said that she was still working on getting the system updated and will upload the updated version, she was aware they are non-compliant with the regulation of posting RN hours as part of the schedule.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to follow standards of practice for insulin administration and needle safety for one resident (Resident #29) of three residents reviewed for insulin administration, resulting in the likelihood of decreased dosage administered and infection. Findings include. On 5/06/2026, at 11:49 AM, Nurse L gathered Resident #29's insulin pen for administration. Nurse L pulled out a needle and attached it to the insulin pen without cleaning the insulin pen with an alcohol swab. Once Nurse L applied the needle to the pen, they turned the administration dial to 8 units and entered Resident #29's room. Nurse L administered the insulin pen without priming the needle with the required 2 units. On 5/06/2026, at 12:32 PM, the Director of Nursing (DON) was alerted that Nurse L did not clean the insulin pen with an alcohol swab prior to the needle attachment nor prime the required 2 units prior to administration.

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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 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 1) Ensure that corrective action was taken when out-of-range temperatures were identified on medication refrigerator temperature logs for one of one medication refrigerator and 2) Discard discontinued or expired topical medications for two of two treatment carts reviewed for medication storage, creating the potential for compromised integrity of temperature-sensitive and topical medications. Findings include: Medication Storage and Labeling: Observed on [DATE] at 8:52 AM with Registered Nurse (RN) [NAME] unit manager of the west resident care unit treatment cart revealed multiple-dose opened ointments and creams used for wound/skin care. Observation noted resident prescription treatments included: Resident #7 -Clotrimazole-Betamethasone .05% external cream. There was no date on the box ad when observed there was no date on the opened tube of medication. Record review of Resident #7's physician order recap noted that Clotrimazole-Betamethasone .05% external cream was ordered [DATE] for 21 days, discontinued [DATE] was still in the treatment cart. Resident #3 - Anaipram HC external cream 2.5oz – box with no date and used tube with no date when medication was opened. Record review of Resident #3's physician order recap noted that 1% Hydrocortisone acetate with pramoxine ordered [DATE] and discontinued [DATE] was still within the treatment cart. Resident #40- Clotrimazole-Betamethasone .05% external cream. There was no date on the box and when observed there was no date on the opened tube of medication. Nystatin 100,000 powder container was opened and used. Record review of Resident #3's physician order recap noted that Clotrimazole-Betamethasone .05% external cream was ordered [DATE] for 21 days, discontinued [DATE] was still in the treatment cart. Nystatin External Powder 100,000 unit/GM started on [DATE] and discontinued on [DATE], was still in the treatment cart. Resident #39- Nystatin 100,000 cream tube was opened and used. There was no date on the box and when observed there was no date on the opened tube of medication. Record review of Resident #39's physician order recap noted that Nystatin External cream 100,000 unit/GM started on [DATE] and discontinued on [DATE], was still in the treatment cart. Resident #96- Nystatin 100,000 powder containers were opened and used. Record review of Resident #96's progress notes revealed that the resident discharged from the facility [DATE] and the resident's medication was still in the treatment cart. Observation and interview on [DATE] at 9:01 AM with Licensed Practical Nurse B of the East unit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235175	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Frankenmuth	500 West Genesee Frankenmuth, MI 48734

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment cart- Resident #5- Nystatin 100,000 powder containers opened and used. There was no date on the container. Resident #68- Mupirocin 2% ointment opened with no date on tube or box. When opening the box, a second tube fell out of triamcinolone 1% with no resident name or date on the tube of cream in the box. Record review of Resident #68's Medication Administration record and Treatment Administration record did not have either ointment/treatment listed. record review on [DATE] at 3:03 PM per team lead and per facility there are no treatment cart policy and no discontinued medication policy. On [DATE] at 1:32PM, an observation of the medication storage refrigerator in the medication storage room that contained biologics, insulin and other temperature sensitive medications, including back up and stock medications. A record review of the refrigerator temperature logs from February 2026 revealed: On [DATE] at 0730AM temperature recorded 34 degrees F. with no evidence of corrective action documented; [DATE] at 0300AM temperature recorded 32 degrees F. with no evidence of corrective action documented; [DATE] at 0800AM temperature recorded 32 degrees F. with no evidence of corrective action documented; and [DATE] at 0730AM temperature recorded 32 degrees F. with no evidence of corrective action documented. On the log was a column labelled Corrective action taken when outside of 36-46 F with no entries made in the column. On [DATE] at 1:45PM, During an interview with the DON, she observed, reviewed and validated that staff acknowledged the temperature deviation on the February log but did not document or initiate corrective steps. The DON was asked what should be done if the temperature is found outside of range and she said they should document it and contact maintenance. The DON was requested to provide policies and procedures medication storage, corrective action plans for refrigerated medications/products and other supporting documents. A record review revealed: No evidence of corrective action. No documents of recalibration, maintenance, replacement or staff re-education. According to a record review of the facilities policy titled Medication storage revealed: it is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommended and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.; And 5. Refrigerated products: b. Temperatures are maintained within 36 to 46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee. c. In the event that a refrigerator is malfunctioning, the person discovering the malfunction must promptly report such findings to the maintenance department for emergency repair. d. In the event that that emergency repairs cannot be made timely, temporary or emergency space is available in the pharmacy refrigerator or the refrigerators located in each medication room.