STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

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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 - Few	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** 31771 Based on observation, interview and record review, the facility failed to ensure dignified care and treatment of two facility residents (R136 and R66) and failed to ensure communication for self-determination of care for one resident (61) of three residents reviewed for dignity. Findings: R136 Review of the Admission Record reflected R136 admitted to the facility on [DATE] with diagnoses that included Osteomyelitis (bone infection) of the left ankle and foot. The medical record reflected R136 was able to make his own medical decisions. Review of the Care Plan for R136 reflected Toileting. (name of R136) will require assistance to the toilet every two hours and as needed. He may utilize a urinal, bed pan, or use the full body lift to the toilet. Initiated 4/4/25. The Care Plan reflected Ambulation/Locomotion (name of R136) is unable to ambulate at this time (due to) NWB (non-weight bearing) status of BLE (bilateral lower extremities) initiated 4/4/25. And the Care Plan reflected Put the call light within reach and encourage him to use it for assistance as needed. Initiated 4/4/25 On 4/8/25 at 7:03 AM an observation and interview were conducted with R136 in his room at the end of the hall. R136 reported he recently admitted to the facility and that he is not a happy camper. R136 reported when he uses his call light staff don't come (to the room) or if staff do come they turn off his call light and don't come back and you have to turn on the light again. R136 reported he could not bear weight on his feet and was unable to walk to the bathroom. R136 displayed his legs which were wrapped with elastic bandages. A urinal was observed within reach. R136 reported he had difficulty holding the urinal in place and has wet himself and the bedding when he has tried to use it on his own. R136 reported he had told staff of this difficulty, but staff did not offer a solution which he reported frustrated him. R136 reported two days prior to this interview he had to have a bowel movement and asked for a bed pan since one had not yet been provided on admission. R136 reported staff could not find one and he was told no one had a key for the room where the bed pans were kept. R136 reported staff told him to 'just poop in the bed and they would clean him up later. R136 voiced harsh criticism of the facility for him having to do this adding, It's humiliating. R136 reported that, although he is continent, he started wearing a brief beginning the previous night (4/7/25) because I never know if they are coming back in five minutes or five hours. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy provided by the facility titled Call Lights last revised 3/12/25 was reviewed. The policy reflected Call lights will be placed within the resident's reach and answered in a timely manner. And Responding to a Call Light: 1. Identify the location and answer the resident promptly 3. Go to the location of the call light and turn off the light if you are able to meet the resident request .5. When finished, turn the call light off and replace the call light within resident's reach. On 4/9/25 at 4:12 PM an interview was conducted with the Director of Nursing (DON) in her office. The DON reported she feels the facility have enough staff to meet the needs of the residents. The DON was informed of the issues raised by R136. The DON indicated that call lights should not be turned off until the need of the resident is met. On 4/10/25 at 9:32 AM a second interview was conducted with R136 in his room. R136 reported the DON had talked to him and that he told her just what I told you. R136 reported he continues to wear a brief because if they don't get to me in time I can just go (void in the brief). R66 Review of the admission record reflected R66 admitted to the facility 3/18/25 with pertinent diagnoses that included difficulty in walking and need for assistance with personal care. The medical record reflected R66 made her own medical decisions and is cognitively intact. On 4/10/25 at 9:44 AM an interview was conducted with R66 in her room. R66 reported delayed call light response or that staff will turn off the call light but not return to help. R66 reported that the due to the delays she has wet herself and reported this has made her feel terrible. R61 Review of the electronic Medical Record (EMR) Admission Record reflected R61 admitted to the facility 3/20/25 with diagnoses that included absence of left and right legs. The Minimum Data Set (MDS) dated [DATE] reflected in Section GG the Resident was dependent on staff for toileting hygiene and all transfers. The medical record reflected R61 was her own decision maker and was a Spanish-speaking only resident. Review of the EMR for R61 did not reveal a communication Care Plan was in place to provide guidance to staff on how to engage this Spanish speaking Resident in her own care. Review of the EMR medical provider documentation of 4/4/25 at 0000 acknowledged the Resident is Spanish speaking only. The documentation reflected that She (R61) says she is painful today but cannot rate it. Denies chest pain, shortness of breath. The documentation reflected Exam Findings appears painful and Resident was weaning off narcotics, will try to continue this with family approval despite the medical record indicating R61 was her own decision maker. The documentation does not indicate the medical provider was Spanish speaking or if translation services were attempted to include input from the Resident in her evaluation. Review of the EMR Progress Note entry dated 4/1/25 at 4:07 AM reflected R61 fell on [DATE]. The documentation reflected Resident is Spanish speaking and could not described (sic) what happened. This entry indicated the Resident could not describe what happened because she was Spanish speaking and does not reflect attempts were made to communicate with the Resident in a way she can communicate. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25 at 4:17 PM an interview was conducted with the Director of Nursing (DON) in her office. The DON reported that the medical provider is not Spanish speaking, but some staff do speak the language. The DON indicated that translation services are available but could not indicate if these had been implemented to ascertain the concerns directly from R61 and engage the Resident in her own care. On 4/10/25 at 10:53 AM in the conference room the Nursing Home Administrator (NHA) acknowledged that R61 did not have a communication Care Plan prior to 4/9/25. The NH reported that R61 can tell staff if she is having pain by rubbing the area and stating Ow. The NHA reported the facility has one Certified Nurse Aide (CNA) and an Activities Aide that speak Spanish but could not say if these staff worked directly with R61.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation and record review, the facility failed to maintain the dignity of one of three residents (Resident #29) reviewed for dignity and respect. Findings: Resident #29 (R29) Review of an Admission Record revealed R29 was a [AGE] year old male, last admitted to the facility on [DATE], who suffered from severe cognitive impairment and depended on staff to meet all of his daily needs. During an observation on 04/09/25 at 11:56 AM, R29 sat in a broda chair at the dining room table and his pants were visibly wet with urine. During an observation on 04/09/25 at 01:04 PM, R29 remained in the broda chair at the dining room table, his pants were visibly wet with urine. During an observation on 04/09/25 at 01:07 PM staff brought R29 from the dining room to the nurses station and placed him next to two other residents. R29's sweat pants remained visibly wet in the crotch area. During an observation on 04/09/25 at 01:23 PM staff took R29 to his room to change his clothing and provide peri-care.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation had two deficient practice statements. DPS A Based on observation and record review, the facility failed to ensure call lights were within reach for 4 of 6 residents (Resident #18, Resident #31, Resident #36, Resident #63) reviewed for accommodation of needs. Findings: Resident #18 (R18) Review of an Admission Record revealed R18 was a [AGE] year old male with pertinent diagnoses of severe intellectual disabilities, seizure disorder, unsteadiness on feet, expressive language disorder, and muscle weakness. During an observation on 04/08/25 at 6:38 AM, R18 laid in bed resting with his eyes closed and the call light touch pad sat on the floor near the foot of the bed out of sight and out of reach of R18. Review of a fall prevention and safety Care Plan for R18 reflected the following intervention .provide R18 with a touch pad call light to assist in calling for staff assistance. Resident #31 (R31) Review of an Admission Record revealed R31 was an [AGE] year old male with pertinent diagnoses of Alzheimer's and right sided weakness, impaired vision, and the inability to speak (aphasia) following a stroke. During an observation on 04/08/25 at 6:54 AM, R31 laid in bed resting with his eyes closed and the call light laid on the floor between the wall and the bed, near the foot of the bed out of sight and out of reach of the resident. During an observation on 04/08/25 at 9:44 AM, R31 sat in a wheelchair bedside in his room and the call light hung clipped near the over bed light, out of reach of the resident. Review of a fall and safety Care Plan for R31 reflected the following intervention .put the call light within reach and encourage him to use it for assistance as needed. Resident #36 (R36) Review of an Admission Record revealed R36 was a [AGE] year old male with pertinent diagnoses of a stroke that caused difficulty speaking and right sided weakness. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/08/25 at 6:32 AM, R36 laid in bed resting with his eyes closed. The call light touch pad hung off the foot of the bed between the mattress and the footboard, out of sight and out of reach of the resident. During an observation on 04/08/25 at 8:49 AM, R36 laid in bed resting with his eyes closed. The door to his room was closed and the call light touch pad hung off the foot of the bed between the mattress and the footboard out of sight and out of reach of the resident. During an observation on 04/08/25 at 9:47 AM, R36 laid in bed resting with his eyes closed. The call light hung off the foot of the bed between the mattress and the footboard, out of sight and out of reach of R36. Review of a fall and safety Care Plan for R36 reflected the following intervention .keep (R36s) environment as safe as possible with the call light within reach .and put the call light within reach and encourage him to use it for assistance as needed. Resident #63 (R63) Review of an Admission Record revealed R63 was a [AGE] year old male with pertinent diagnoses of aphasia and muscle weakness following a stroke and dementia. Review of the facility policy Call Lights reflected .when a resident is in bed or confined to a chair ensure the call light is within reach of the resident. During an observation on 04/08/25 at 6:57 AM, R63 laid in bed resting with his eyes closed and the call light touch pad sat on at chair at the foot of the bed on top of two pillows, out of sight and out of reach of the resident. Review of a safety and fall Care Plan for R63 reflected the following intervention .put the call light within reach and encourage him to use it. 37573 DPS B Based on observation, interview and record review, the facility failed to assist in accommodating Durable Medical Equipment (DME) for one resident (R48) of one resident reviewed for DME to assist with an appropriate and comfortable fitting wheelchair that will accommodate his needs. Findings include: Review of a Face Sheet revealed R48 originally admitted to the facility on [DATE] with pertinent diagnoses of communicating hydrocephalus (excessive accumulation of cerebrospinal fluid (CSF) within your brain ventricles), hemiplegia and hemiparesis (one sided weakness), abnormal posture, stiffness of left hip, stiffness of left knee, contracture of right and left ankle. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) dated [DATE] revealed R48 is cognitively intact and has limited range of motion (LROM) on one side of his upper and lower extremity. R48 requires a wheelchair for mobility and is dependent on staff for transfers. Review of an email correspondence dated from the Ombudsman (OB) Y dated 4/4/25 revealed concerns of R48 not receiving a proper DME assessment and consideration for an appropriate fitting wheelchair. Several attempts were made to assist in guiding the facility to get insurance to pay for it and the facility neglected to submit the paperwork in time. The resident (R48) wants to have an electric wheelchair, and the Medical Supply Providers are trained to fit residents for all types of DME which includes wheelchairs. The facility expressed concerns of safety for R48 in an electric wheelchair, but the Medical Supply Provider can equip the wheelchair with sensors and mirrors among other things to keep R48 comfortable, safe, and functional. The Ombudsman had talked with the Administration in the past advocating for R48 to be assessed for an appropriate fitting wheelchair and did not understand why the facility was not following through and doing what they need to do. The family had reached out to the Ombudsman several times with their concerns that the facility not addressing their needs. They have tried several different wheelchairs, but they were not a personalized approach to specifically fit R48's needs. The Ombudsman also stated that the DME Policy Specialist was also involved with assisting the facility getting insurance approved for an appropriate fitting wheelchair too. They have had several care conferences to explain the processes and the facility has failed to follow through. Review of an Email Correspondence between the Ombudsman and the Facility Social Worker on 1/7/25 revealed: Social Worker: We still have ongoing issues with the family of R48 complaining about wheelchairs again. They do not have an understanding of why we cannot order him a chair while he is in the facility. Insurance will not pay for a wheelchair while he is in facility. He has been assessed over and over and has changed wheelchairs several times. When he got his current chair, he liked it and would propel himself up and down the halls independently. We are reassessing him for a RoHo as he used to have one. Ombudsman response: Insurance actually will pay. I am happy to involve [DME Policy Specialist] again, if needed. The issue last time is that the paperwork was submitted late by the facility, and it must be submitted within the window given by Medicaid. Review of an Email Correspondence dated 2/28/25 revealed the Facility Social Worker had reached out to the Ombudsman regarding insurance coverage for wheelchairs (No resident was mentioned) and the Ombudsman responded with attachments which included power points, fact sheets and an application with instructions for an Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices. Review of an Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices-Completion Instructions revealed: This form should be completed for NEW or REPLACEMENT mobility device(s) and seating systems. It must be submitted with the Complex Seating and Mobility Device Prior Approval - Request/Authorization (MSA-1653-D). The evaluation and justification must be submitted within 90 days of the date the evaluation was completed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and an interview on 4/8/25 at 9:00 AM, R48 is in the dining room sitting in a soft back wheelchair with no head support. He is sitting upright at the table waiting for his breakfast with his mother who is also his Guardian. They reported they are not happy and have filed several grievances with the facility that are not being addressed and do not communicate with her. One concern was regarding a wheelchair that would fit R48 appropriately. R48 cannot sit in a regular wheelchair for long periods of time because of his pressure points and contractures. He does have painful bladder spasms that interfere with his movements. There is no cushion that is comfortable for him, and he needs a headrest to hold up/support his head. When R48 is leaning back in his wheelchair that tilts back, he is unable to hold his head up. He reported he is in pain all the time and said his pain is in his shoulder and his left hip mostly, but he has overall generalized pain. R48 wants an electric wheelchair, and the facility refuses to let him have one. The wheelchairs he has tried do not fit him appropriately and are uncomfortable. He can only be up so long in his current wheelchair before he lays down in bed to relieve the pressure in his body and his neck. In an interview on 4/9/25 at 1:53 PM, Occupational Therapist (OT)/Manager Z reported R48 was assessed for a high-backed wheelchair with no headrest due to the potential of losing his neck control. OT Z reported R48 can recline in his wheelchair but reiterated there is no headrest. OT Z reported the electric wheelchair is not good for R48 because he cannot turn his head and encourages him to use his neck muscles (even though he is contracted). He has had several wheelchairs in the past that did not work for him because he would either slide out of them or they were uncomfortable. His current wheelchair now is a High Back 22 and does not have a headrest. When asked if there was a way to get a head rest, OT Z reported there is one in the closet in the therapy room. When asked if she, having no contractures, would be comfortable in a recliner holding her head up without support after a while, she agreed she would not be comfortable. OT Z pulled out the head rest for R48's wheelchair that presented as a sling type device that slides on to the back of R48's wheelchair. OT Z reported they have not tried it before but will try it on his wheelchair today. OT Z then reported that the facility does not always have the resources for needed equipment and has discussed R48's wheelchair concerns in the Interdisciplinary (IDT) meetings and said, if they give the family what they want, they always want more. In an interview on 4/9/25 at 2:42 PM, the Director of Nursing (DON) reported she has had conversations about a head rest for R48 with his Guardian about a month ago, but not with R48 himself. The DON reported therapy saw R48 in the past and only knows what therapy had reported and is recommending. They are trying to help R48 keep good muscle and truck control so he can keep being as independent as possible. During an observation and an interview on 4/9/25 at 3:30 PM, R48 was lying in bed and reported he likes being in his wheelchair as long as he can but needs something to take the edge off his tailbone. When he reclines his chair to relieve the pressure from his tailbone, he must hold up his neck with no support and reported it is hard to do. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/10/25 at 9:44 AM, Social Worker (SW) U reported she is aware of the grievances from R48 and his mother (Guardian). R48 is young and has unrealistic expectations for endless therapy. R48 is not safe for a power wheelchair because of his left sided deficit. The therapy department did assessments for R48 to evaluate him for safety and said he is not safe in an electric wheelchair. The family is upset and now they want to go someplace else for care. When asked about R48's wheelchair not having any head support especially when he is reclined back, SW U reported he does look uncomfortable and then said he needs a specialty wheelchair. SW U then reported she thinks there is a way to get him approved for a new fitted wheelchair and said she reached out to the Ombudsman back in January. SW U then pulled up her emails to show she did reach out to the Ombudsman who replied to her on how to proceed but SW U had more questions and reported the Ombudsman never replied to the follow up email. When asked why she didn't follow up with it, she reported she will reply now at this time. During an observation and an interview on 4/10/25 at 10:47 AM, R48 was observed in the dining room with his sling headrest attached to his wheelchair. His head is contracted forward and does not touch the headrest. R48 reported he needs something between his head and the headrest so his neck and head would be supported. Review of a Grievance Form dated 2/24/25 for R48 revealed: INFORMATION ABOUT YOUR CONCERN: Getting (R48) a wheelchair that he can sit in without being in so much pain. Pressure point relief chair. (sic) Who else know about the problem or incident? The whole staff. Then the concern proceeded to explain how R48 was in so much pain, and this has been an ongoing problem for 3 years. The facility responded on 3/12/25 with Resident was provided with a high back, tilting wheelchair with a roho (pressure relieving device) cushion on 2/10/25 (before this complaint). ACTION TO BE TAKEN: Staff education on inflating ROHO cushion as needed. Resident continues to work with therapy for positioning and various other things to help relieve pressure. R48's Guardian marked the box at the end of this grievance I am not satisfied with the response to my request for assistance. I request that the administrator review my complaint and provide me with a response. No follow up response from the NHA is documented on the grievance form. Review of a Grievance From dated 3/12/25 for R48 revealed: INFORMATION ABOUT YOUR CONCERN: (R48) needs a headrest on his wheelchair to be able to lay back and rest his tail bone. (Staff name) says she wants him to hold his head up. The wheelchair still doesn't fit him right. He needs to be able to adjust himself, not have to wait until someone comes to help him. When did this problem or incident occur? Every day when he's up and laying back in his chair. Is this an ongoing problem? Yes, for 3 years. Have you contacted us in the past about this issue? Yes, All of the staff. Facility Response: Resident evaluated by Therapy for a headrest. Therapy not currently recommending a headrest because it will negatively affect what muscle tone resident has. Action to be Taken: Therapy will follow up and re-evaluate as needed. Documents signed by the Guardian on 3/31/25 that she is not satisfied with the outcome and requested the Administrator to review her complaint and provide a response. No follow up response from the NHA is documented on the grievance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/10/25 at 11:35 AM, the Nursing Home Administrator (NHA) reported they are now setting up a care conference with the Ombudsman and the DME Policy Professional for R48 regarding his wheelchair needs. The NHA confirmed the family really wants him to have a power wheelchair, but he cannot be safe in the building with one. R48 has had several wheelchairs since he has been at the facility. One wheelchair hurt his buttocks too much, so they got him a high back wheelchair that tips back to relieve pressure, but he could not self-propel when it is tipped back. R48 wants to propel himself but he has pain sitting in the upright position. The NHA reported she is not sure what kind of wheelchair will help him. The NHA reported the Medical Supply Company did fit him for wheelchair but R48 needs to be at his maximum function before he can be fitted for one so they can establish a baseline. When asked when the last time the Medical Supply Company came in to assess R48, the NHA did not have an answer. When the NHA was asked to explain the process for getting an appropriate fitting wheelchair, the NHA reported that once the original paperwork is sent to the DME Provider, they assess the resident and try to build a potential wheelchair to see how the resident can fit in it and adjust accordingly. A timeline was requested for the efforts by the facility to find an appropriate wheelchair to accommodate R48's needs. No assessments provided to show the Medical Supply Company came out to assess the residents' special needs for an appropriate fitting wheelchair and no documentation provided to show the facility tried to submit the appropriate paperwork needed to the insurance provider by the end of this survey.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 31771 Based on observation, interview, and record review, the facility failed to respond to grievance issues raised by the Resident Council resulting in an ineffective forum for the presentation of grievances and recommendations to the facility affecting all facility residents. Findings: On 4/8/25 at 9:59 AM an interview was conducted with R60 who reported she was the Resident Council President. R60 reported two main issues are regularly raised by the Resident Council at monthly meetings. R60 reported one issue is delayed call light response. R60 also reported that call lights are often turned off and staff leave the room without meeting the resident's needs but claiming they will return shortly. R60 reported staff frequently fail to return to the resident's room after turning off a call light and indicated the Resident Council attendees have expressed frustration over this. The second issue is that meals are not served on time and that the Dining Room would be filled with residents waiting for long periods of time for food to be served. R60 reported the facility will say they will investigate these concerns but that the group is never given a follow up report on the issues. R60 reported that, consequently, these two issues are recurring topics at Resident Council meetings. On 4/9/25 at 1:40 PM an interview was conducted with Activities Director (AD) L who reported she acted as the facilitator for monthly Resident Council meetings. AD L reported that during the Resident Council meeting all departments were reviewed. AD L reported she documents the issues discussed and if there are any concerns a Concern Form is generated on the spot for the given issue. AD L reported the concerns are addressed with the appropriate departments and the response is reviewed at the next Resident Council meeting. AD L was asked to provide the Resident Council documentation for the previous six months. AD L reported she will provide the documentation and include any Concern Forms generated. The monthly Guest/Resident Council minutes for October 2024 through March 2025 were reviewed. The review did not reveal any documentation of resident concerns of delayed assistance requests or slow meal services. Review of generated Concern Forms revealed one resident had raised an individual concern of room cleanliness in February 2025 and this issue was revisited in March 2025. The documentation of the other four months reflected We didn't have any concerns from last council or this council. All Guest/ Resident Council minutes provided reflected a signature of the Nursing Home Administrator (NHA) indicating the minutes had been reviewed by the NHA. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/25 at 9:45 AM a Resident Council meeting was convened in the Dining Room. Members of the confidential group reported that call light timeliness is an ongoing issue. Members reported that staff will come into the room, turn off the light, and don't come back. One member reported she gets frustrated when you need a diaper, or you need to go to the bathroom, and you just sit there. The confidential group agreed that mornings are the worst time of the day to need assistance because of the slow response stating, we wait a lot. One member stated that she has not complained directly to staff and did not want her name mentioned because the staff might take it offensively. The confidential group also reported it is generally believed that residents must be in the Dining Room early especially for breakfast but end up waiting an hour to an hour and a half before the meal is served. One member stated that the long wait cuts into my personal time. The members of the confidential group also reported that when food starts to come out of the kitchen not everyone at a table will be served at the same time. The members reported that residents at the same table will finish their meal and leave the dining room before other residents, that have waited for an hour or more, have not been served. Another resident reported sometimes breakfast isn't served until almost 9;00 AM and that lunch follows soon after indicating a short time span between meals. The confidential group reported that AD L does take notes but that concerns raised at previous Resident Council meetings are not rehashed. The members reported that the group is not informed of any actions taken to address their concerns. Summary timeline of observations of morning meal Dining Service on 4/8/25 in the [NAME] Dining Room: 7:37 AM - 13 residents present. No staff present. Some residents have beverages. 7:55 AM -17 residents present. No staff in room. Some residents getting beverages for other residents from a cart. 8:04 AM- 20 residents present. Staff bringing residents in by wheelchair then leave after positioning the residents at tables. One staff member dispensing silverware. 8:27 AM- 28 residents in Dining Room. No meal has been served. 8:37 AM - First meal out of kitchen. 8:50 AM- 6 tables of 11 tables have been served. Two staff passing meals. One staff member taking orders for the noon meal. 9:00 AM - Last resident served meal. This resident was one of the 13 residents present in the room when the initial observation was documented at 7:37 AM. On 4/10/25 at 12:04 PM an interview was conducted with the NHA. The NHA was informed of the issues raised by the confidential group and that the group reported facility was not responding to their concerns. The NHA indicated she was not aware of the Resident Council's concerns. As of survey exit no further information was provided.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 37573 Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS) assessments in 1 (R23) of 18 residents reviewed for accuracy of MDS assessment, from a total sample of 18. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, October 2024, Chapter 3 Section O: Special Treatments, Procedures and Programs, revealed .The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods .The treatments, procedures, and programs listed in Item O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life .Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs . J1. Dialysis, J2. Hemodialysis, J3. Peritoneal dialysis Review of the Facility Matrix provided at the beginning of this survey revealed R23 receives hemodialysis. In an interview on 4/8/29 at 11:40 AM, R23 reported he leaves the facility 3 days a week to go to dialysis. Review of an admission MDS assessment, with a reference date of 6/6/24, Section O for Special Treatments and Programs, entry J1 Dialysis, J2 Hemodialysis, revealed R23 was not checked for receiving dialysis. Review of an MDS assessment, with a reference date of 9/5/24, Section O for Special Treatments and Programs, entry J1 Dialysis, J2 Hemodialysis, revealed R23 was not checked for receiving dialysis. Review of an MDS assessment, with a reference date of 3/4/25, Section O for Special Treatments and Programs, entry J1 Dialysis, J2 Hemodialysis, revealed R23 was not checked for receiving dialysis. In an interview on 4/10/25 at 9:28 AM, the MDS Coordinator/ Registered Nurse (RN) W verified R23 was not triggered/marked for dialysis even though he does receive dialysis and reported it should have been marked on the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on interview and record review, the facility failed to formulate and implement a comprehensive communication Care Plan for one non-English speaking resident (R61) of one resident reviewed for communication. Findings: Review of the Admission Record reflected R61 admitted to the facility 3/20/25 with diagnoses that included absence of left and right legs. The medical record reflected R61 was her own responsible party and was a Spanish speaking resident. Review of the Electronic Medical Record (EMR) for R61 did not reveal a communication Care Plan to provide guidance to staff on meeting the needs of this Spanish speaking Resident. Review of the medical provider documentation of 4/4/25 acknowledged the Resident is Spanish speaking only. The documentation reflected that She (R61) says she is painful today but cannot rate it. Denies chest pain, shortness of breath. The documentation reflected Exam Findings appears painful and Resident was weaning off narcotics, will try to continue this with family approval despite the medical record indicating R61 was her own decision maker. The documentation does not indicate the medical provider was Spanish speaking or if translation services were attempted to include input from the Resident in her evaluation. Review of the EMR Progress Note entry dated 4/1/25 at 4:07 AM reflected R61 fell on [DATE]. The documentation reflected Resident is Spanish speaking and could not described (sic) what happened. This entry indicates the Resident could not describe what happened because she was Spanish speaking and does not reflect attempts were made to communicate with the Resident in a way she can communicate. On 4/9/25 at 4:17 PM an interview was conducted with the Director of Nursing (DON) in her office. The DON reported that the medical provider is not Spanish speaking, but some staff do speak the language. The DON was informed that no Care Plan to assist staff in communication with the Resident was located. The DON indicated she would conduct a review. On 4/20/25 at 10:53 AM in the conference room the Nursing Home Administrator (NHA) acknowledged that R61 did not have a communication Care Plan prior to 4/9/25. The NHA reported the facility has one Certified Nurse Aide (CNA) and an Activities Aide that speak Spanish but could not say if these staff worked directly with R61.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to 1.) accurately document the administration of controlled medications and 2.) ensure controlled medications were administered following the providers order for 4 of 7 residents (Resident #75, #78, #62, and #80), reviewed for controlled medication administration. Findings: Resident #75 (R75) Review of an Admission Record revealed R75 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R75's Order Summary dated 8/9/24 revealed, Temazepam Oral Capsule 15 MG (Temazepam) *Controlled Drug* Give 1 capsule by mouth at bedtime for Severe Manic Bipolar 1 Disorder with Psychotic Behavior. Review of R75's Controlled Substances Proof of Use form revealed the temazepam was not documented as dispensed on 4/5/25. Review of R75's Medication Administration Record revealed the temazepam was documented as administered. Review of R75's Order Summary dated 2/9/25-2/12/25 revealed, LORazepam (Ativan) Oral Tablet 1 MG (Lorazepam) *Controlled Drug* Give 1 mg by mouth every 6 hours as needed for Anxiety and agitation for 3 Days. Review of R75's Controlled Substances Proof of Use form revealed: *On 2/8/25 at 8:00 PM a dose of Ativan was dispensed (prior to the start date of the Ativan). *On 4/6/25 at 7:53 PM a dose of Ativan was dispensed (without an active order for the Ativan.) Review of R75's Medication Administration Record revealed no documentation that the Ativan was administered. Review of R75's Electronic Medical Record revealed no documentation for the administration of the Ativan or a physicians one time order for the Ativan. Resident #78 (R78) Review of an Admission Record revealed R78 was a [AGE] year-old male, admitted to the facility on [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R78's Order Summary revealed LORazepam Oral Tablet 0.5 MG (Ativan) Give 1 tablet by mouth every 04 hours as needed for Agitation for the following dates: *1/19/25-2/2/25 *2/13/25-2/14/25 *2/14/25-2/28/25 Review of R78's Controlled Substances Proof of Use form revealed: *On 2/9/25 at 7:00 AM a dose of Ativan was dispensed (without an active order for the Ativan.) *On 2/9/25 at 8:30 PM a dose of Ativan was dispensed (without an active order for the Ativan.) *On 2/13/25 at 8:00 PM a dose of Ativan was dispensed. *On an illegible date (later confirmed by Nursing Home Administrator [NHA] and Director of Nursing [DON] as 2/14/25 at 4:00 AM) a dose of Ativan was dispensed. Review of R78's Medication Administration Record revealed no documentation that the Ativan was administered. Review of R78's Electronic Medical Record revealed no documentation for the administration of the Ativan on 2/9/25 or a physicians one time order for the Ativan. Resident #62 (R62) Review of an Admission Record revealed R62 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R62's Order Summary dated 9/17/25 revealed, HYDROcodone-Acetaminophen (Norco) Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) *Controlled Drug* Give 1 tablet by mouth every 8 hours as needed for Mild Pain. Review of R62's Controlled Substances Proof of Use form revealed: *On 3/6/25 at 8:00 PM a dose of Norco was dispensed. *On 3/30/25 at 1:29 PM a dose of Norco was dispensed. Review of R62's Medication Administration Record revealed no documentation that the Norco was administered on 3/6/25 at 8:00 PM or on /30/25 at 1:29 PM. (Documentation that as needed medication is administered is necessary to ensure the ongoing need for the medication and adequate control of symptoms). Resident #80 (R80) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed R80 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R80's Order Summary dated 3/25/25-3/26/25 and 3/26/25 revealed, LORazepam (Ativan) Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 0.5 mg orally every 4 hours as needed for anxiety/excessive crying . Review of R80's Controlled Substances Proof of Use form revealed: *On 3/26/25 at 9:45 AM a dose of Ativan was dispensed. *On 3/26/25 at 10:00 PM a dose of Ativan was dispensed. *On 3/31/25 at 9:00 PM a dose of Ativan was dispensed. Review of R80's Medication Administration Record revealed no documentation that the Ativan was administered on 3/26/25 at 9:45 AM, on 3/26/25 at 10:00 PM, or on 3/31/25 at 9:00 PM. During an interview on 4/09/25 at 02:56 PM, DON and NHA confirmed the medication errors (medications administered without an order) for R75 and R78 as well as the documentation errors for R75, R78, R62, and R80. DON and NHA reported that nurses should be administering medications with a physician's order and should be documenting the administration of medications. DON and NHA reported the licensed nurses that made medication administration errors would be receiving 1:1 education as well as all licensed nursing staff. Review of the facility policy Medication Administration last revised 10/17/23 revealed, .Physician's Orders - Medications are administered in accordance with written orders of the attending physician .1. Verify the medication label against the medication administration record for resident name, time, drug, dose, and route . 2. Record the result of medications administered as necessary .Record the dose, route, and time of medication on the Medication/Treatment Administration Record. Document if the resident refused.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to 1.) ensure comprehensive nursing assessments were completed and 2.) identify and notify the provider of a change in condition for 1 resident (Resident #85) out of 3 residents reviewed for quality of care. Findings: Resident #85 (R85) Review of an Admission Record revealed R85 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Progressive multifocal leukoencephalopathy (progressive damage/inflammation of brains white matter.) Review of R85's provider Progress Note dated 1/9/25 revealed, .Resident guardian has continued to request resident be sent to hospital for any acute changes in health status. Due to resident decline it is expected that he will be resent to hospital at some point . Review of R85's Hospital Discharge Records revealed the following hospitalization s since his admission to the facility: *10/31/24-11/6/25 severe sepsis *11/9/24-11/10/24 fever with unspecified fever cause *11/21/24-11/26/24 recurrent aspiration pneumonia *12/4/24-12/10/24 sepsis and acute hypoxic respiratory failure *12/11/24-12/14/24 sepsis and recurrent aspiration pneumonia *12/29/24-1/8/25 acute respiratory distress *1/14/25-1/17/25 sepsis and recurrent aspiration pneumonia Review of R85's Electronic Health Record revealed R85 required suctioning on 12/11/24, 12/29/24, and 1/14/25 Confirming R85 had significant chronic respiratory conditions which required multiple hospitalization s and nursing interventions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R85's Respiratory Care Plan revealed, Interventions .Observe for s/sx (signs and symptoms) of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB (shortness of breath) at rest, Cyanosis, Somnolence. Report abnormal findings to the physician .Observe for s/sx of respiratory infection: elevated temp, change in level of consciousness, malaise, Chills, increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing. Report abnormal findings to the physician . Review of R85's Nurses Notes dated 1/21/25 revealed, Resident was reddened in color. pulse 119 alerted on call . (Normal adult heart rate is between 60-100 per [NAME] and [NAME]: Fundamentals of Nursing) Indicating a change in R85's condition. Review of R85's vital signs Summary revealed the last full assessment of vital signs (temperature, pulse, blood pressure, oxygen level, respirations) was completed on 1/21/25 at 3:10 PM. Review of R85's Temperature Summary revealed R85's last documented temperature was on 1/23/25 at 2:23 PM. Review of R85's Sepsis Screening Evaluation dated 1/24/25 at 1:33 AM revealed, Does the resident have two or more symptoms checked? Yes . This had not been previously identified on the evaluations following R85's return to the facility on [DATE]. Indicating a change in R85's condition and the possibility of sepsis should have been further assessed/evaluated. Additionally, R85's last full set of vital signs (temperature, pulse, blood pressure, oxygen level, respirations) were noted in this assessment. There were no additional Sepsis Screening Evaluations completed prior to 1/26/25. Review of R85's Nurses Notes dated 1/24/25 at 12:21 PM revealed, Resident presenting with fever of 101.6, Tylenol given immediately. P.A (Physician's Assistant) notified and wants to manage fever in house for now, if unable to get fever to break will need to send him out to hospital. Will continue to monitor. (a fever is a temperature above 100.4 F (38 C) for an adult per [NAME] and [NAME]: Fundamentals of Nursing). Indicating temperature monitoring was to be implemented to ensure R85 was physiologically stable to remain in the facility. Review of R85's Order Summary dated 1/17/25 revealed, Acetaminophen (Tylenol) Liquid 160 MG/5ML Give 20 ml enterally every 8 hours as needed for Pain . Review of R85's Medication Administration Note dated 1/24/25 at 12:14 PM revealed a dose of Tylenol was administered for Fever 101.6. Review of R85's Medication Administration Note dated 1/24/25 at 12:51 PM revealed fever improving with no temperature results noted. Review of R85's Medication Administration Note dated 1/25/25 9:51 AM revealed a dose of Tylenol was administered for given for fever prevention with no temperature results noted. Review of R85's Electronic Medical Record from 1/17/25-1/26/25 revealed no documentation of a provider assessment following his readmission to the facility. There was no comprehensive respiratory assessment (lung sounds, rate, rhythm, depth, dyspnea, pain, sputum) completed by licensed nurses following his readmission assessment on 1/17/25 despite his significant and chronic respiratory conditions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R85's Nurses Notes dated 1/26/25 revealed, Went into resident's room to change drain sponge and observed him non responsive, checked for a pulse and called (additional) nurse for assistance, checked code status. RN (Registered Nurse) pronounced time of death at 0535 (5:35 AM) . During an interview on 04/10/25 at 09:22 AM, Nursing Home Administrator (NHA) (NHA is a Registered Nurse and the previous Director of Nursing) reported that she would expect nurses to assess temperatures if administering Tylenol for a fever as well as the provider reporting he wanted to treat R85's fevers in the facility. NHA reported she would expect licensed nurses to complete respiratory assessments on someone that returned to the facility due to sepsis from a respiratory illness. NHA reported that the providers were to assess residents upon their return from a hospitalization but confirmed there was no provider assessment for R85. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Perform respiratory assessment, including symmetry of chest wall expansion, chest wall abnormalities (e.g., kyphosis), temporary conditions (e.g., pregnancy, trauma) affecting ventilation, respiratory rate and depth, sputum production, lung sounds, and signs and symptoms associated with hypoxia .Observe for cognitive and/or behavioral changes (e.g., apprehension, anxiety, confusion, decreased ability to concentrate, decreased LOC, fatigue, and dizziness). CLINICAL JUDGMENT: Patients with sudden changes in their vital signs, LOC, or behavior may be experiencing profound hypoxia. Patients who demonstrate subtle changes over time may have worsening of a chronic or existing condition or a new medical condition ([NAME] et al., 2020). [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1003). Elsevier Health Sciences. Kindle Edition.

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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** 37573 Based on observation, interview and record review, the facility failed to follow policies and procedures and prevent a facility acquired pressure ulcer, had conflicting assessment documentation, and revise the care plan for one (R27) of three residents reviewed for pressure ulcers. Findings include: Review of the Facility Matrix provided by the facility at beginning of this survey on 4/8/25 revealed R27 was not documented as having a pressure ulcer. Resident #27 (R27) Review of a Face Sheet revealed R27 admitted to the facility on [DATE] with pertinent diagnoses of a displaced fracture of the left humerus (long bone in arm from the shoulder to the elbow), diabetes, and obesity. No pressure ulcers. Review of an admission Nursing Comprehensive Evaluation dated 2/24/25 for R27 revealed no pressure ulcers upon admission. Review of the admission Braden Scale for Predicting Pressure Sore Risk for R27 dated 2/24/25 revealed she was at a low risk for developing pressure sores. Review of a Skin and Wound Evaluation dated 3/18/25 for R27 revealed she had a new onset of an In-House Acquired stage II pressure ulcer on the left heel that measured 22.3 cm2 (centimeters squared) X 6.1 cm X 5. 1 cm. Review of the Nurse Practitioner progress note dated 3/18/25 (the same day as the Skin and Wound Evaluation) for R27 revealed: Wounds Notes: L (left) heel: Affected area approx . 6.1x5.1cm (sic) with ?blister-like? film covering (sic). No significant drainage. So (sic) surrounding erythema . Pressure ulcer of left heel, unstageable- New onset. -Admits to previous pressure ulcer to left heel. (sic) Review of Nursing Progress note dated 4/3/25 at 2:06 PM for R27 revealed: Left heel pressure stage II is deteriorating this week. Treatment in place. MD (medical doctor) Aware. Action Taken: Continue with current plan of action. Educated patient on use of heel [NAME] and compliance. This intervention is not on the care plan. Review of a Practitioner Progress note dated 4/7/25 for R27 revealed: Per staff, unstageable area to her left heel started bleeding quite a bit in the night, appears to be from the superior end of the eschar (dead tissue that falls off from the skin). . Bordered foam dressing applied to the area. Review of a Skin & Wound Evaluation dated 4/8/27 for R27 revealed a Stage II In-House Acquired pressure ulcer on the left heel measuring 7.1cm2 X 3.6 cm X 3.0 cm, eschar. (continued on next page)

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Regency at Fremont	4554 W 48th St Fremont, MI 49412

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and an interview on 4/9/25 at 8:27 AM, R27 was observed sitting up in bed at a 90-degree angle and the heels of her feet were resting on top of the foot board and she confirmed she does have a pressure ulcer on her left heel. At this time, she turned her call light on for care and the Nursing Home Administrator (NHA) (who is also a Registered Nurse) answered the call light and observed R27's heels on the footboard and reported the resident is too far down in her bed. Review of a Care Plan for R27 revealed she is a risk for impaired skin integrity/pressure injury related to immobility, initiated on 2/24/25 and revised on 3/4/25. Despite the admission Braden Scale assessment indicated she was a low risk. No new interventions since the onset of her pressure ulcer on 3/18/25. In an interview on 4/9/25 at 11:33 AM, Nurse Practitioner (NP) V reported R27 does have an unstageable pressure ulcer and is not sure why the facility would document the wound as a stage II. NP V reported she was under the impression that R27 was admitted with a pressure ulcer. Review of a policy titled Skin Management last approved 9/19/24 revealed: It is the policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. 3. Appropriate preventative measures will be implemented on residents identified at risk and the interventions are documented on the care plan. 5. The licensed nurse will initiate documentation in the electronic health record, which includes a description of the skin impairment as follows: o In Electronic Health Record (EHR) facilities, the licensed nurse will document on the skin and wound evaluation for pressure injury and vascular ulcers. 7. An initial care plan is developed upon admission/readmission if the resident is at risk or has a pressure injury and the comprehensive care plan may address: - Identifying the contributing risk factors for breakdown, including history of skin impairment or actual impairment, Hydration, Nutrition, Preventative devices, including recumbent and seated support surfaces, . Proper body alignment, Education - when appropriate. 13. Resident's with pressure injury and lower extremity ulcers will be evaluated, measured and staged weekly (pressure injury and vascular ulcers only) in accordance with the practice guidelines until resolved. 15. Care plan and resident Kardex will be updated accordingly. 16. The DON (Director of Nursing) designee will document any changes in the care plan/Kardex at the meeting.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview, and record review, the facility failed to safely transport residents in wheelchairs for 6 residents (Resident #50, #43, #31, #1, #7, and #37) out of 6 residents reviewed for accidents and hazards. Findings: Resident # 50 (R50) Review of an Admission Record revealed R50 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Alzheimer's Disease, unsteadiness on feet, history of falling, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for R50, with a reference date of 2/3/25 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated R50 was severely cognitively impaired. During an observation on 04/09/25 at 09:04 AM, Certified Nursing Assistant (CNA)F pushed R50 in a wheelchair without footrests from the dining room to the nurses station on the 500 hall. At 09:06 AM, CNA F pushed R50 in a wheelchair without footrests from the nurses station down the hall to her room. During an observation on 04/09/25 at 1:43 PM, CNA F pushed R50 in a wheelchair without footrests from the nurses station to the middle of the 500 hall. During an interview on 04/09/25 at 1:50 PM, Licensed Practical Nurse (LPN H) stated that for safety reasons, residents must have their feet securely on footrests when being pushed by staff. Resident #43 (R43) Review of an Admission Record revealed R43 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Alzheimer's Disease, unsteadiness on feet, history of falling, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for R43, with a reference date of 1/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated R43 was severely cognitively impaired. During an observation on 04/09/25 at 08:53 AM, Activities Aide (AA) L pushed R43 in a wheelchair without her feet on footrests with her left foot dragging on the ground from the nurses' station to the activities/dining room. R43 was wearing grip socks. Resident #31 (R31) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed R31 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Alzheimer's Disease and muscle weakness. Review of a Minimum Data Set (MDS) assessment for R31, with a reference date of 3/5/25 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated R31 was severely cognitively impaired. During an observation on 04/09/25 at 09:15 AM, CNA N pushed R31 in a wheelchair without his feet on footrests from the main dining room to nurses station. R31 was wearing tennis shoes, and his feet were dragging on the floor. CNA N put his feet up on the footrests when his tennis shoes prevented her from pushing him further in the wheelchair. 37577 Resident #1 (R1) Review of an Admission Record revealed R1 was a [AGE] year old male with pertinent diagnoses of left sided weakness following a stroke, seizure disorder, and mood fluctuations related to a traumatic brain injury. During an observation on 04/09/25 at 1:36 PM, Certified Nurse Aide (CNA) F pushed R1 in a wheelchair without footrests from his doorway to the 400 hall spa room. Resident #7(R7) Review of an Admission Record revealed R7 was an [AGE] year old female with pertinent diagnoses of dementia, restlessness and agitation, and anxiety disorder. During an observation on 04/08/25 at 8:59 AM, CNA D pushed R7 in a wheelchair without footrests from the nurses station to the resident's room on the 500 hall. Resident #37 (R37) Review of an Admission Record revealed R37 was a [AGE] year old female with pertinent diagnoses of dementia and epilepsy. During an observation on 04/08/25 at 12:22 PM, employee E pushed R37 in a wheelchair without any footrests from the nurses station to the resident's room at the end of the 400 hall.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based in interview and record review the facility failed to act upon a Pharmacy recommendation for a psychoactive medication for one facility resident (R137). Findings: Review of the Electronic Medical Record (EMR) reflected R137 admitted to the facility 3/20/25 with diagnoses that included non-Traumatic Brain Dysfunction. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderate cognitive impairment. Review the EMR revealed a medication pharmacy review for R137 was conducted on 3/22/25 and the pharmacist had documented a recommendation. Review of the EMR documentation titled Consultation Report dated 3/22/25 revealed a pharmacy recommendation that R137 had a (as needed) Doctor's Order for the anxiolytic medication Lorazepam without a stop date. The pharmacy recommendation reflected the requirement for as-needed non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration of the (as-needed) order. This Consultation Report reflected the Physician's Response was I accept the recommendation(s) above . The consultation Report was signed and dated 3/26/25 by the medical provider. On 4/9/25 at 3:00 PM the Doctor's Orders for R137 reflected a current order for Lorazepam 0.5 milligram (mg) to be given every 4 hours as needed . with an order date and start date of 3/20/25. The order did not reflect a required 14 day stop date (4/2/25). Review of the EMR for R137 did not reveal documentation by the prescriber of a diagnosed specific condition being treated or a rationale for the extended time period. The review of the Doctor's Orders and the EMR reflected that, although the pharmacy recommendation was accepted, it was not acted upon and R137 was still receiving the Lorazepam seven days past the recommended stop date without documented rationale. On 4/9/25 at 4:11 PM the Director of Nursing (DON) was informed that no documentation was found that the acknowledged pharmacy review of 3/22/25 for R137 had been acted upon. The DON reported she would conduct a review. On 4/10/25 at 9:03 AM the DON acknowledged that the pharmacy review of 3/22/25 for R137 had not been acted upon

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review, the facility failed to maintain best practices in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: During the initial tour of the kitchen, starting at 7:15 AM on [DATE], an interview with Certified Dietary Manager (CDM) X, found that most food items are held for three days. An observation of the two door Victory refrigeration unit, at 7:25 AM on [DATE], found a bag of sliced turkey dated ,d+[DATE] to ,d+[DATE]. During a tour of the Masterside Kitchenette, starting at 8:24 AM on [DATE], an interview with CDM X found that dietary comes and checks the refrigeration unit daily for restock and housekeeping cleans the refrigeration unit. Further observation inside of the unit found 10 expired yogurts with best by dates of [DATE]th, [DATE]th, and [DATE]th. Observation of the J Wing Kitchenette, at 8:34 AM on [DATE], found 12 nutritional juice drinks and shakes stored in the unit with no date to indicate when to discard the product. Review of the products manufacture label states the items are good for 14 days upon thaw. When asked if she would know when they were thawed, CDM X was unsure, stating that most of the time they have a name and date and should be used for a snack at night. Further observation of the unit found two expired yogurts with best by dates of [DATE]th. According to the 2022 FDA Food Code section ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, 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. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 FDA Food Code section ,d+[DATE].18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in ,d+[DATE].17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in ,d+[DATE].17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . During an interview with CDM X, at 7:36 AM on [DATE], it was observed that the inside mechanism for creating ice was found to have hoses and surfaces with black accumulation. When asked who cleans the machine, CDM X stated staff clean the outside and we have vendor that deep cleans the inside. When asked when the last time the vendor was onsite, CDM X was unsure. During a tour of the clean utensils' drawers, at 7:48 AM on [DATE], two mechanical scoops were found stored with an accumulation of dried on food debris inside the scoop and behind the scoop arm. During a tour of the kitchen, at 8:03 AM on [DATE], it was observed that the inside top of the microwave was found with an accumulation of dried food debris. According to the 2022 FDA Food Code section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. During the initial tour of the kitchen, at 7:44 AM on [DATE], it was observed that a disposable Styrofoam coffee cup was stored in a large container of powdered milk. The cup was found with no handle and covered in powdered milk dust. During the initial tour of the kitchen, at 7:46 AM on [DATE], it was observed that five spatulas stored hanging over the preparation table, were found to be chipped and torn with missing pieces off the edge of the utensils. When asked if these spatulas were still used, CDM X stated yes. According to the 2022 FDA Food Code section ,d+[DATE].12 In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the food with their handles above the top of the food and the container; . According to the 2022 FDA Food Code section ,d+[DATE].11 Characteristics. Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be: P (A) Safe; P (B) Durable, CORROSION-RESISTANT, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated WAREWASHING; (D) Finished to have a SMOOTH, EASILY CLEANABLE surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the facility, at 8:25 AM on [DATE], it was observed that the ice chest cooler, near the Masterside Kitchenette, was found with a visible accumulation of water, with no means for the water to self-drain and not accumulate among the ice. When asked about how the facility takes care of the ice coolers, CDM X stated they get cleaned daily. During a tour of the J Wing Kitchenette, at 8:33 AM on [DATE], it was observed that the ice chest cooler was found with an accumulation of water in the ice chest, with no means the water to self-drain and not accumulation among the ice. According to the 2022 FDA Food Code section ,d+[DATE].12 Storage or Display of Food in Contact with Water or Ice.(B) Except as specified in (C) and (D) of this section, unPACKAGED FOOD may not be stored in direct contact with undrained ice .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to implement infection control practices for wound and peri-care for two (R66 and R29) of two residents and follow blood borne practices for one (Resident #30) of one residents, reviewed for infection control. Findings include: Resident #66 (R66) Review of a Face Sheet revealed R66 readmitted to the facility on [DATE] with pertinent diagnoses of necrotizing fasciitis and diabetes. During an observation on 4/8/25 at 7:37 AM, Licensed Practical Nurse (LPN) O was providing surgical wound care for R66. LPN O removed the old dressing that was packed into the wound and cleansed the wound with normal saline. She changed her gloves with no hand hygiene and proceeded to pack the wound with long gauze soaked with Dakins solution. The tail end of the gauze was touching the residents clean brief and her leg. LPN O continued with packing the wound. When LPN O completed the dressing change, she removed her gown that was caught on her hair tie and removed her gloves. She fixed her hair with no hand hygiene and walked into the hallway to find hand sanitizer. In an interview on 4/8/25 at 8:00 AM, LPN O reported she should have performed hand hygiene when changing her gloves and the gauze should not have touched R66's brief or leg. Review of a policy titled Clean Dressing Change last revised 9/18/23: 7. Remove old dressing and discard in the appropriate disposal bag. 8. Remove gloves. Perform hand hygiene. Apply clean gloves. 9. Cleanse wound/site gently with solution ordered. Wash from the center of the wound/site to the periphery. 13. Discard soiled materials in plastic bag. Remove gloves and wash hands. 37577 Resident #29 (R29) Review of an Admission Record revealed R29 was a [AGE] year old male, last admitted to the facility on [DATE], who suffered from severe cognitive impairment and depended on staff to meet all of his daily needs. During an observation on 04/09/25 at 1:30 PM, Certified Nurse Aide (CNA) N assisted R29 from a broda chair to his bed to provide peri-care and a clothing change, after R29's sweatpants were observed to be saturated with urine. During the same observation, CNA N performed peri-care in the following manner: (a) cleaned the crease of R29's legs, (b) then cleaned the scrotum, (c) then wiped the shaft of the penis, and then cleaned the urethral opening. During the same observation, after R29 was cleaned up and staff left the room, CNA N did not sanitize or clean the broda chair that the resident had been sitting in with urine soaked pants on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy/procedure Perineal (peri) care for the male patient reflected the following: wash the penis with a washcloth, beginning at the tip and working in a circular motion from the center to there periphery to avoid introducing microorganisms into the urethra. Wash the rest of the penis using downward strokes toward the scrotum. 31771 Resident #30 (R30) Review of the medical record reflected R30 admitted to the facility 5/16/18 and has a current pertinent diagnoses of diabetes mellitus. On 4/8/25 at 8:18 AM while awaiting breakfast service in the [NAME] Dining Room, Licensed Practical Nurse (LPN) O was observed wearing gloves performing a blood glucose level test on R30 at a dining table with another resident present sitting at the table and twenty other residents in the room. On 4/9/25 at 4:29 PM an interview was conducted with the Director of Nursing (DON) in her office. The DON was informed of the observation of a blood sugar test being performed in a communal dining area prior to meal service. The DON indicated that this is not OK and would be contrary to facility policy. A review of [NAME] and [NAME] (2021), revealed that when the nurse uses a blood glucose monitor, they should Provide privacy and prepare beside environment for patient safety. Therefore, the resident should be brought to their room before using a blood glucose monitor on a resident and/or administering an injection. (Fundamentals of Nursing- Tenth Edition, Chapter 31, p 652, p 659, and p. 1145, Mosby). Review of the documentation provided by the facility dated 11/19/24 and titled Blood glucose monitoring, long-term care was reviewed. The documentation reflected Implementation . provide privacy.