STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235184	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Nursing and Rehabilitation	3011 North Center Road Flint, MI 48506

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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 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** This Citation pertains to Intake Number 2988534. Based on interview and record review, the facility failed to ensure coordination of care with external care providers for one resident (Resident #701) of three residents reviewed. Findings include:Resident #701:Review of intake documentation revealed a concern that facility staff were provided a medication prescription by Resident #701's orthopedic surgeon for Valium (controlled, antianxiety medication commonly used before surgery to reduce anxiety) on 4/7/26 to take before their scheduled surgery on 4/13/26 but the facility did not administer the medication. Record review revealed Resident #701 was admitted to the facility on [DATE] with diagnoses which included displaced transcondylar fracture of the right humerus (serious fracture where bones are not aligned near the elbow), periprosthetic fracture around internal prosthetic left shoulder joint (break in bone around artificial joint), left knee laceration, right shoulder replacement, heart disease, depression, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required maximum to total assistance to complete Activities of Daily Living (ADLs).Review revealed Resident #701 was transferred back to the hospital on 4/13/26 and did not return to the facility. An interview was completed with Resident #701 on 5/5/26 at 10:37 AM. When queried, Resident #701 revealed they went to the hospital after leaving the facility and stated, I had to have another two surgeries. When queried if they received their medications while at the facility, Resident #701 revealed the staff did not always tell them what they were giving them. Review of documentation in Resident #701's Electronic Medical Record (EMR) revealed the following: - 4/7/26 at 4:20 PM: Nursing/Clinical. returned from Ortho appointment with new orders for. Valium 5 mg (milligrams) 24 hrs (hours) prior to surgery and 12 hours prior to surgery. No time given yet. Patient needs revision of ORIF (Open Reduction and Internal Fixation - surgical procedure) to Rt (right) Humerus. Do not remove splint- may remove ace wrap and rewrap it as needed. - 4/7/26 at 4:30 PM: Nursing/Clinical. returned from ortho appt, no new orders given, no concerns noted or reported. - 4/9/26 at 5:57 PM: Nursing/Clinical. noted blood to Rt elbow with cast placed. unable to remove cast ABD pads (wound dressing) placed and ace bandage applied. ortho aware d/t (due to) patient calling them. No new orders given, patient to have surgery on the rt elbow on Monday the 13th. - 4/10/26 at 11:18 AM: PMR (Physical Medicine and Rehabilitation) follow up (Health Care Provider- HCP Note) . consulted by the primary medical team to optimize therapy, pain control, and discharge planning. Follow up with PCP (Primary Care Provider) and specialists as disclosed. Set to have RUE (Right Upper Extremity) surgery on 4/13/26. - 4/13/26 at 1:30 PM: Nursing/Clinical. transported by daughter to (Hospital) for scheduled surgical procedure. NPO (nothing by mouth) except for medications and sips of clear liquids up until 12pm on the 4/13/26. Review of Resident #701's HCP orders revealed one order for Valium. The order was dated 4/13/26 and specified, Valium 5 mg. 1 tablet by mouth every 24 hours as needed for Anxiety. (Start Date: 4/13/26; Hold from 4/13/26 to 4/14/16 for surgical procedure). A review of Resident #701's Medication Administration Record (MAR) revealed Resident #701 did not receive any Valium while at the facility.Further review of Resident #701's HCP orders revealed the order, NPO (Nothing by Mouth) at midnight every shift for 1 Day may have clear liquids up until 2 hours before procedure (Ordered: (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/9/26; Start Date: 4/12/26). Review of scanned documentation in Resident #701's EMR revealed no consultation documentation from the external orthopedic provider appointment on 4/7/26. There was a scanned prescription from the external orthopedics provider dated 4/7/26 for Valium 5 mg, 1 tablet 12 hours prior to surgery and 24 hours prior to surgery. An interview was completed with Infection Control (IC) Licensed Practical Nurse (LPN) E on 5/5/26 at 12:00 PM. LPN E was asked where the consultant report for Resident #701's orthopedic appointment was in Resident #701's EMR. LPN E reviewed the Resident's EMR and verbalized there was no consultation note. When queried regarding the scanned script for Valium in Resident #701's EMR and facility policy/procedure related to scripts from external HCPs, LPN E revealed the medication recommendations are typically put in the orders. An interview was completed with the Director of Nursing (DON) on 5/5/26 at 1:52 PM. When asked if Resident #701 was admitted to the facility for skilled services, the DON responded they were. When queried regarding the prescription scanned into Resident #701's EMR from the external orthopedic provider, the DON stated, (Resident #701) didn't get the Valium. When asked if Resident #701 should have received the Valium as directed on the prescription from the orthopedic provider, the DON verbalized the order should have been entered but was missed. When queried regarding consultation notes/documentation from the orthopedic provider appointment on 4/7/26, the DON confirmed there was no documentation from the orthopedic provider in Resident #701's EMR and indicated they would attempt to locate it. An interview was completed with Unit Manager Registered Nurse (RN) D on 5/5/26 at 3:22 PM. When queried regarding consultation documentation from the provider for Resident #701's external orthopedic appointment on 4/7/26, RN D stated, I don't know where it is at but I remember seeing it. RN D confirmed they wrote the Nursing/Clinical note dated 4/7/26 at 4:20 PM in Resident #701's EMR and verbalized they obtained the information they put in the note from the consultation report. When queried regarding the prescription for Valium, RN D stated, The script was for pre-op. I didn't put in the order because I didn't have the surgical date. RN D explained the consultation documentation did not specify the planned date of the surgery and they were unable to put the order for Valium in the EMR without a date. When queried regarding the NPO order for surgery being entered into the EMR on 4/9/26 by LPN N and HCP documentation dated 4/10/26 specifying the Resident was having surgery on 4/13/26, RN D stated, In hindsight it got missed. With further inquiry, RN D revealed other facility staff are responsible for making external appointments and they were not notified of the surgical date and did not enter the order in Resident #701's EMR. When asked about the facility procedure for entering orders from external HCPs, RN D revealed they (Unit Managers) review the recommendation and enter orders into the EMR. Resident #701's written orthopedic provider consultation notes for their appointment on 4/7/26 was located and provided by the DON on 5/6/26. Review of the Physician's Consultation Notes did not provide any additional information pertaining to the Valium and/or surgical date. Review of facility provided policy/procedure entitled, Outside Appointments/Consults (Reviewed 12/25) revealed, Our facility will assist residents in arranging outside appointments/consults when necessary. 4. Consult form will be used for communication. 5. Outside recommendations from appointments/consults will be reviewed by the facility provider.

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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** This Citation pertains to Intake Number 2986995. Based on interview and record review, the facility failed to correctly assess the wound status of one resident (Resident #702) upon admission of three residents reviewed, resulting in a lack of timely and comprehensive identification, and the assessment and care of an alteration in skin integrity. Findings include:Resident #702: Review of intake documentation revealed a concern that Resident #702 was admitted to the facility on [DATE] with no alterations in skin integrity. The Resident was transferred back to the hospital on 4/15/26 due to a change in condition with skin tears and a black eye. An interview was completed with Family Member Witness A on 5/4/26 at 12:10 PM. When queried regarding Resident #702, Witness A responded that the Resident passed away. When asked, Witness A disclosed Resident #702 went to the facility on 4/11/26 for therapy after having a CVA (stroke) which resulted in their right side being flaccid and aphagia (difficulty speaking). Witness A revealed the Resident was transferred back to the hospital on 4/15/26 due to a change in condition and did not return to the facility. Witness A verbalized concerns related to the care Resident #702 received at the facility. Witness A stated that when Resident #702 was transferred back to the hospital on 4/15/26 their Bottom was excoriated and they had two briefs on. Witness A stated the Resident's brief was full of bm and urine. Witness A stated, (Resident #702) had a black eye and a large skin tear on their right upper extremity and lower extremity. Witness A explained Resident #702 did not have the any skin tears when they went to the facility. Witness A was asked if the Resident had a fall or injury at the facility and responded that no family member had been notified of any falls/injuries. Witness A continued, I called the DON (Director of Nursing) to let them know and they were very passive-aggressive. Witness A was asked what they meant and responded (The DON) told me it was charted on the 13th or 14th. I told (the DON) that (Resident #702) was admitted on the 11th and (the Resident) did not have any skin tears when they were admitted . Witness A verbalized the DON asked them if it was their friends at the hospital who told them that and said, I was very concerned being a nurse. Witness A proceeded to provide time and location stamped images of Resident #702's right arm dated 4/15/26 at 9:30 PM at the hospital. The picture showed a saturated, kerlix (gauze wrap) dressing in place on the Resident's right arm just under the arm of their hospital gown. A second picture with a location stamp at the hospital, dated 4/16/26 at 2:55 AM, showed bruising around Resident #702's right eye. Record review revealed Resident #702 was admitted to the facility on [DATE] and discharged on 4/15/26 with diagnoses which included depression, chronic kidney disease, myocardial infarction (heart attack), and cerebrovascular accident (CVA-stroke) with resulting right sided weakness, dysphagia (difficulty swallowing) and anarthria (difficulty with expressive speech). Review of the Minimum Data Set (MDS) assessment, dated 4/15/26, revealed that the Resident was rarely/never understood and required maximum-to-total assistance to complete Activities of Daily Living (ADL). Review of Resident #702's Nursing Assessment Admission/Readmission dated 4/11/26 at 7:00 PM detailed, Skin: Is there a skin issue present? Yes. 16) Left antecubital: Bruising 15) Right antecubital: Bruising 29) Right hand (back): Bruising 30) Left hand (back): Bruising. Review of documentation in Resident #702's Electronic Medical Record (EMR) revealed no documentation pertaining to the Resident's skin until 4/13/26. The documentation specified, - 4/13/26 at 9:22 AM: Nursing/Clinical. Skin Assessment: Extensive Bruising to BUE (Bilateral Upper Extremities) and hands in various stages of healing from hospital IVs (Intravenous access) and blood draws. Skin over entire body is thin and fragile which may contribute to skin tears and other skin integrity issues. Skin tear with full flap loss to RUE (Right Upper Extremity) superior to AC (antecubital- inner elbow), surrounding tissue is intact with bruising, no drainage noted. Skin tear with full flap loss to posterior RUE at triceps, surrounding tissue is intact with bruising, no drainage noted. Treatment Plan: Cleanse skin tear to RUE superior to AC with NS (Normal Saline), pat dry, apply xeroform to wound bed and cover with dry dressing QD (every day) and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PRN (as needed). Cleanse skin tear to posterior RUE at triceps area with NS, pat dry, apply xeroform to wound bed and cover with dry dressing QD and PRN.- 4/13/26 10:24 AM: SW - Skin Issues. Skin Issue: #001: New skin Issue. Location: Above right elbow. Issue type: Skin tear. Progress: New: new wound. Type 3: Total flap loss. Wound was present on admission. It is unknown how long the wound has been present. Length: 2.57 centimeters (cm), Width: 4.54 (cm). Surrounding tissue: Dark reddish brown. Fragile. Skin Issue: #002: New skin Issue. Upper right outer arm. Skin tear . new wound. Total flap loss. Wound was present on admission. It is unknown how long the wound has been present. Length: 4.15 (cm) Width: 1.43 (cm). Surrounding tissue: Dark reddish brown . Discoloration. Intact. Fragile. Review of Resident #702's SBAR/Change in Condition assessment dated [DATE] at 6:10 PM detailed, Skin Evaluation.Right antecubital right upper fa (facility acquired) skin tear. Review of Resident #702 Health Care Provider (HCP) orders revealed there were no orders in place for wound care until 4/13/26. The treatment orders included:- Cleanse skin tear to RUE superior to AC with NS, pat dry, apply xeroform to wound bed and cover with dry dressing QD and PRN. every day shift every 3 day(s) (Start: 4/13/26) - Cleanse skin tear to RUE triceps area with NS, pat dry, apply xeroform to wound bed and cover with dry dressing QD and PRN. as needed (Start: 4/13/26) - Cleanse skin tear to RUE triceps area with NS, pat dry, apply xeroform to wound bed and cover with dry dressing QD and PRN. every day shift every 3 day(s) (Start: 4/13/26) A review of Resident #702's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2026 revealed the start dates of the treatments did not match the HCP order. The following were included on the MAR and TAR:- An as needed (PRN) order to Cleanse skin tear to RUE triceps area with NS, pat dry, apply xeroform to wound bed and cover with dry dressing QD and PRN every day shift every 3 day(s) (Start Date: 4/13/26).There was no documentation indicating the treatment had been completed. - A scheduled order to Cleanse skin tear to RUE triceps area with NS, pat dry, apply xeroform to wound bed and cover with dry dressing QD and PRN every day shift every 3 day(s) (Start Date: 4/14/26).The treatment was documented as completed on 4/14/26. - A scheduled order to Cleanse skin tear to RUE superior to AC with NS, pat dry, apply xeroform to wound bed and cover with dry dressing QD and PRN every day shift every 3 day(s) (Start Date: 4/16/26)There was no documentation indicating the treatment had been completed. Review of Resident #702's EMR revealed a care plan entitled, I am at risk for altered skin integrity related to decreased mobility, weakness, debility, recent pacemaker placement, high risk for falls that could result in skin alteration, advanced age, impulsivity with poor safety awareness (Initiated: 4/11/26; Revised: 4/13/26). The care plan did not include any specific interventions pertaining to the Resident's altered skin integrity. Admit 4/11 Skin tear with full flap loss to posterior RUE at triceps, surrounding tissue is intact with bruising, no drainage. related to: friction (Initiated and Revised: 4/13/26). The care plan included the intervention, Administer treatment per physician orders (Initiated: 4/13/26).A second care plan entitled, Admit 4/11 Skin tear with full flap loss to RUE superior to AC, surrounding tissue is intact with bruising, no drainage noted related to: friction (Initiated and Revised: 4/13/26) and included the intervention, Administer treatment per physician orders (Initiated: 4/13/26). An interview was conducted with Wound Care Licensed Practical Nurse (LPN) E on 5/5/26 at 12:36 PM. LPN E was asked when they first assessed Resident #702's skin tears and replied 4/13/26. When queried regarding the etiology of the skin tears on Resident #702's RUE, LPN E responded that the skin tears were present upon Resident #702's admission to the facility. LPN E was asked how they knew the skin tears were present when the Resident was admitted and responded, I took off a dressing with one of our nurses' initials on it, so it was present on admission. When queried whose initials were on the dressing, LPN E revealed they did not know. LPN E was then asked to review Resident #702's wound care orders. After review, LPN E was queried when treatment order for the skin tears were first entered into the Resident's EMR and responded 4/13/26. When queried why a nurse at the facility would complete a wound dressing without a HCP order, LPN E replied, I can't speak to what other people do. LPN E was then asked to review Resident #702's EMR for documentation of the skin tears prior to 4/13/26. After reviewing the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EMR, LPN E stated, I don't see anything (documentation) before mine (on 4/13/26). LPN E was then asked if it could be possible that the skin tears were not present when the Resident was admitted to the facility and stated, Could be. When queried if there should be documentation when a resident is admitted if there are open areas/skin tears, LPN E replied, Yes. LPN E explained they utilize the wound camera and complete wound staging, but floor nursing staff document the present of any abnormalities. LPN E was asked what admission nurses should document and responded they should document any skin alterations, the location, and approximate size. On 5/5/26 at 2:11 PM, an interview was completed with Registered Nurse (RN) F. When queried if they provided care to Resident #702, RN F revealed they were the Resident's assigned nurse on 4/15/26 when they were transferred to the hospital. When queried, RN F responded that was the first time they had provided care to Resident #702. When queried regarding Resident #702's skin integrity, RN F replied, They (other nurse) said (Resident #702) had a skin tear on their arm when they got report. When asked, RN F revealed they did not look at and/or assess the skin tear due to sending the Resident to the hospital. An interview was completed with LPN G on 5/5/26 at 2:19 PM. When queried, LPN G confirmed they admitted Resident #702 to the facility. LPN G was asked if they completed a skin assessment on the Resident and responded they did. When queried what they do when they complete a skin assessment, LPN G revealed they observe all areas of the skin for any abnormalities. When asked if the Resident had any skin tears on their skin when they were admitted , LPN G stated, (Resident #702) had multiple bruising on their upper extremities but they did not have a skin tear. LPN G verbalized they documented the Resident's skin assessment in the admission assessment. LPN G stated, I also told the DON that (Resident #702) didn't have a skin tear when they asked me too. LPN G was asked when the DON asked them about Resident #702's skin and were unable to recall the specific date. LPN G stated, The DON called me and kept asking like they wanted me to say it (skin tear) was there when it wasn't. I wasn't comfortable with that. On 5/5/26 at 3:00 PM, an interview was conducted with Certified Nursing Assistant (CNA) H and CNA L. When queried if they provided care to Resident #702, both staff verbalized they had. When asked if the Resident had a skin tear and/or wound dressing in place on their RUE, both CNA H and CNA L replied, No. An interview was completed with Unit Manager RN D on 5/5/26 at 3:38 PM. When queried regarding the skin tears on Resident #702's RUE, RN D stated, My impression was that they were present on admission. When queried where it was documented that the skin tears were present when the Resident was admitted , RN D reviewed the Resident's EMR and verbalized there was no documentation of Resident #702's skin tears until 4/13/26. RN D was asked where the skin tears came from as there was no documentation of them being present upon admission and stated, I see where you're coming from. Upon request for any Incident and Accident and/or concern forms with corresponding investigation documentation for Resident #702, the following was provided:- 4/17/26: Complaint/Grievance Report. Describe Concern in Detail: Arrived at hospital double briefed, black eye, and skin tears. not aware of skin concerns. Findings of Investigation: Interviewed staff, Patient did not have black eye at d/c (discharge) to hospital. Skin tears were present upon admission. CNA did double brief Resident. Plan. Education to CNAs in regarding to double briefing. Education to nurses in regards to accurate skin assessments at admission. - Unsigned Statement form for LPN G: Date of Interview: 4/21/26. over phone. Were you (Resident #702's) nurse when admitted to facility on April 11th? Yes. Did you complete a skin check? Yes. Did (Resident) had any skin tears upon admission? . Didn't notice at time of admission. Did you do a thorough skin check without looking at every part of skin? . don't think I removed gown.Review of the schedule/assignment sheets revealed LPN G worked the afternoon shift on 4/11/26. - Signed Statement by CNA J dated 4/20/26. The statement included, Do you know the condition of (Resident #702's) skin on their arms? I didn't notice any skin tears but (the Resident) was in the chair out by the nurses' station. I didn't really do anything with their arms, I just changed (the Resident's) brief. On Sunday, I do remember (Resident #702) kept pulling their hospital gown off and they had a blanket on them that we had to keep pulling up and readjusting their gown. Maybe (Resident #702) scratched (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their arm or something.Review of facility schedule/assignment sheets revealed CNA H worked on 4/11/26 and 4/15/26. - Signed Statement by RN M dated 4/30/26. The statement detailed, Do you know the condition of (Resident #702's) skin on their arms? You received report from 2nd shit that (Resident) had skin tear on arm, don't remember what arm. Did (Resident #702) have a dressing on their arm? Yes.Review of facility schedule/assignment sheets revealed RN M worked midnight shift on 4/11/16, 4/12/26, and 4/13/26. - Signed Statement by RN F dated 4/17/26. The statement specified RN F was Resident #702's nurse when they were transferred to the hospital and that the Resident had a skin tear on their right arm that was bandaged up.Review of facility schedule/assignment sheets revealed RN F worked on 4/15/26. - Signed Statement by Wound Care LPN E dated 4/24/26 which detailed Resident #702 had a bandage covering a skin tear on their arm that I removed, took picture and then replaced with a new dressing.Wound Care LPN E worked on 4/13/26. - Signed Statement by CNA J dated 4/20/26. The statement included, Did you notice any skin tears on (Resident #702's) skin? Yes, did have bandages but I can't remember which arm it was.Review of the schedule/assignment sheets revealed CNA J worked day shift on 4/15/26, after Resident #702's wound care treatments were implemented. - Signed Statement by RN O dated 4/17/26 which detailed Resident #702 had two skin tears.Review of the schedule/assignment sheets revealed RN O worked the afternoon shift on 4/13/26 after Resident #702's wound care treatments were implemented. On 5/5/26 at 6:00 PM, an interview was completed with RN M. When queried if they provided care to Resident #702, RN M verbalized they were assigned to the Resident on midnight shift the day they were admitted . When queried if the Resident had any skin tears, RN M replied they believe they were informed that the Resident had a skin tear in report. RN M stated, There was a bandage on it as well. It was not huge. RN M was asked what type of bandage was covering the wound and replied, A Band-Aid. When asked to clarify if the skin tear was covered with a normal size Band-Aid, RN M replied, Like a bigger Band-Aid. When queried if they assessed the skin tear, RN M replied, No and revealed they only saw the band-aid. When asked if the Resident's RUE was wrapped with Kerlix gauze, RN M replied, No, not that I remember. RN M then stated, I remember I documented it somewhere. A review of Resident #702's no documentation of the Resident's skin tears by RN M.Review of facility schedule/assignment sheets revealed RN M worked midnight shift on 4/11/16, 4/12/26, and 4/13/26. On 5/6/26 at 9:00 AM, an interview was completed with CNA J. When queried if they had provided care to Resident #702, CNA J verbalized they had on the day the Resident was transferred to the hospital (4/15/26). When queried, CNA J stated, I remember (Resident #702) having bandages on their left arm. Review of staffing/schedule sheets revealed LPN N was assigned to Resident #702 on 4/15/26 during the day shift.An interview was conducted with LPN N on 5/6/26 at 9:25 AM. When queried if they recalled Resident #702, LNP N verbalized they did. LPN N was asked about the skin tears and dressings on Resident #702's right arm and revealed they did not remember the Resident having a wound dressing in place on their arm. LPN N stated, I do remember bruising though. When asked if the Resident's arms were covered with clothing, LPN N stated, Always wore a (hospital style) gown and indicated the Resident's arms were visible. Review of staffing/schedule sheets revealed CNA K was assigned to Resident #702 on 4/11/26 and 4/12/26 on the midnight shift.On 5/6/26 at 10:07 AM, an interview was conducted with CNA K. When queried if Resident #702 had wound dressings in place on their arm, CNA K stated, I do not remember seeing bandages on their arms. When queried regarding care provided and if they observed the Resident's arms, CNA K stated, (Resident #702) did have an accident and we changed their gown. When asked what they meant when they said we, CNA K replied, I did have another aide assist me every time with (Resident #702) because they didn't move their legs well. Review of staffing/schedule sheets revealed CNA I was assigned to Resident #702 during the afternoon shift on 4/12/26.An interview was completed with CNA I on 5/6/26 at 10:25 AM. When queried, CNA I verbalized they remembered Resident #702. CNA I was asked if they changed the Resident's brief during their shift and verbalized, they had. When queried if they had changed Resident #702's gown, CNA I stated, Yeah. CNA I was asked if Resident (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#702 had any wound dressings in place on their arms and stated, I don't remember seeing him with any really. CNA I then stated, (Resident #702) would unrobe a lot at the nurses station. When asked if the Resident always wore a gown, CNA I replied, Yeah but they would always take it off. A review of requested documentation from the hospital for Resident #702's hospital stay from 3/30/26 to 4/11/26 was completed. There was no documentation in the hospital medical records, including the discharge medical records to the facility of Resident #702 having a skin tear and/or of a wound care treatment for a skin tear. An interview was completed with the DON on 5/6/26 at 1:20 PM. When queried regarding the etiology of Resident #702's skin tear, the DON stated, Had it before they came here. The DON was asked why there was no documentation of the skin tear being present upon admission in the nursing and/or HCP documentation and replied, The nurse didn't do a complete (skin) assessment. When asked why none of the other nurses assigned to care for the Resident identified, assessed, and documented information pertaining to the skin tear until 4/13/26 if it was present upon admission, the DON revealed the nurses did not receive a task to complete or do anything with the skin tear because there was no order. When queried why the facility nursing staff did not identify that the skin tear was not being addressed, if it was present upon admission, the DON did not provide an explanation. The DON was then asked if they were aware that there was no documentation of the Resident having a skin tear and/or wound treatment/dressing in place at the hospital and upon discharge to the facility and stated, I know. The DON stated, (RN D) and I reviewed the documentation from the hospital today. When queried how they could say the skin tears did not occur at the facility, when there is no documentation of the Resident having a skin tear when they were discharged from the hospital and no documentation of the skin tear being present at the facility until 4/13/26, the DON stated they did not receive an Incident and Accident report about Resident #702's skin while at the facility and RN M said there was a dressing in place on midnight shift. When queried regarding RN M stating Resident #702's skin tears being covered with a large band aid as well as stating they documented on the skin tear when there was no documentation present, the DON verbalized RN M must have meant a border foam dressing. When queried why RN M said band-aid if the wound was not covered with a band-aid and why they would say the skin tear was not huge when it was a large skin flap, the DON did not provide further explanation. When queried regarding the lack of implementation and documentation of treatment for the wound until 4/13/26, the DON verbalized understanding. No further explanation was provided. An interview was completed with the Administrator on 5/6/26 at 2:10 PM. When queried why Resident #703's skin tear was not reported as an injury of unknown origin, the Administrator replied, We determined that (Resident #702) came with it. Review of facility provided policy/procedure entitled, admission Assessment and Follow Up: Role of the Nurse (Revised: 1/26) revealed, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission. 8. Conduct a physical assessment, including the following systems. j. Skin. 12. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The following information should be recorded in the resident's medical record. 3. All relevant assessment data obtained during the procedure. Review of facility provided policy/procedure entitled, Wound Care (Revised: 1/26) revealed, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the wound care was given. 4. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. Review of facility provided policy/procedure entitled, Abuse and Neglect Procedural Guidelines (Reviewed: 9/2025) revealed, Abuse, neglect. of any kind against residents, by any person, is strictly prohibited. Prevention. The resident has the right to be free from any form of abuse. Neglect: failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2986995. Based on interview and record review, the facility failed to identify, comprehensively assess, and document nutritional/hydration needs and intake for one resident (Resident #702) of three residents reviewed for quality of care resulting, in a lack of identification of risk for dehydration, timely initiation of a Health Care Provider (HCP) ordered diet, documentation of fluid intake, and a decline in health status. Findings include:Resident #702: Review of intake documentation revealed a concern that Resident #702 was admitted to the facility on [DATE] and transferred back to the hospital on 4/15/26 due to confusion and a change in condition. An interview was completed with Family Member Witness A on 5/4/26 at 12:10 PM. When queried regarding Resident #702, Witness A responded that the Resident passed away. When asked, Witness A disclosed Resident #702 went to the facility on 4/11/26 for therapy after having a CVA (stroke) which resulted in their right side being flaccid and expressive aphagia (difficulty speaking). Witness A revealed the Resident was transferred back to the hospital on 4/15/26 due to a change in condition and did not return to the facility. With further inquiry regarding the reason Resident #702 was transferred back to the hospital, Witness A stated, (Resident #702) was severely dehydrated and in acute kidney failure. Witness A revealed they were a Registered Nurse (RN) and stated Resident #702's laboratory values related to kidney function were normal when they left (the hospital) on the 11th (4/11/26). Witness A verbalized Resident #702 was completely orientated and alert when they left the hospital on 4/11/26 and was unresponsive and not responsive when they were transferred to the emergency room (ER). When asked, Witness A revealed Resident #702 was able to respond to yes/no questions and understood what people were saying. When queried if they visited the Resident at the facility, Witness A revealed they did not and stated, I talked to the nurse on the phone, and she said (Resident #702) was more confused and not drinking or eating. Witness A was asked when the phone conversation occurred and replied, Monday. Witness A continued, (Family Member Witness B) went there (to facility) and said (Resident #702) was not good. (Witness B) said (Resident #702) was very confused and couldn't even nod their head to answer questions. Record review revealed Resident #702 was admitted to the facility on [DATE] and discharged on 4/15/26 with diagnoses which included depression, chronic kidney disease, myocardial infarction (heart attack), cardiac pacemaker placement on 4/3/26, Benign Prostatic Hyperplasia (BPH- enlarged prostate), and cerebrovascular accident (CVA-stroke) with subsequent right sided weakness, dysphagia (difficulty swallowing) and anarthria (difficulty with expressive speech). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and required maximum to total assistance to complete Activities of Daily Living (ADLs) including eating.Review of Resident #702 Health Care Provider (HCP) orders revealed the Resident did not have a diet order in the Electronic Medical Record (EMR) until 4/13/26. On 4/13/26, the diet, General diet Puree texture, Nectar consistency was ordered. Review of Resident #702's Nursing Assessment Admission/Readmission dated 4/11/26 at 7:00 PM revealed the Resident had No natural teeth or tooth fragments, did not have dentures, and their food intake was Adequate: Eats over half of most meals. Resident #702's Nursing Assessment Admission dated 4/11/26 at 7:00 PM included a section titled, Oral and Nutrition. Initial Care Planning which included sections for initial care plans related to oral/dental health problems, swallowing problems, and nutritional or potential nutritional problems. None of the initial care plans pertaining to alterations/potential alterations in nutrition were selected and implemented. Review of Resident #702's care plans in the EMR revealed a care plan entitled, I am at risk for injury related to handling and drinking of hot liquids (Initiated: 4/11/26; Revised: 4/13/26). The care plan included the interventions, Cup with lid or other adaptive cup (Initiated: 4/7/26) and Staff assistance with hot liquids (Initiated: 4/7/26). Resident #702 also had a care plan entitled, I have an ADL self-care performance deficit related to. (Initiated: 4/11/26; Revised: 4/13/26) in their EMR. This care plan (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included the intervention, Eating: I require set up assistance to eat (Initiated: 4/7/26). A care plan entitled, I have a nutritional problem. (Initiated: 4/11/26; Revised: 4/14/26) was also present in Resident #702's EMR. The care plan did not include a diet and/or any specific dietary interventions until 4/14/26.On 4/14/26 the following interventions were added to the care plan:- Monitor for s/sx (signs/symptoms) dysphagia: difficulty or excessive chewing, difficulty or pain swallowing, holding/pocketing food in mouth, spillage of food from mouth, coughing/choking. (Initiated: 4/14/26)- Diet as ordered: general, puree, nectar thick liquids (Initiated and Revised: 4/14/26) Review of Resident #702's Kardex included the interventions, I require set up assistance to eat and Cup with lid or other adaptive cup. The Kardex did not include the Resident's diet including modified diet/fluids. Review of Resident #702's task documentation and the Documentation Survey Report revealed the Resident did not have documentation of oral fluid intake and/or amount of urine output. There was task documentation for the percentage of meal eaten and bedtime snack. The task documentation detailed Resident #702 detailed the following:- 4/11/26: A Bedtime Snack was accepted at 8:09 PM.- 4/12/26: 11:54 AM: 100% eaten; 12:08 PM: 100% eaten; 5:59 PM: 25% eaten. A Bedtime Snack was accepted at 3:57 PM.- 4/13/26: 12:35 PM: 0% eaten (same data documented twice at the same time); 8:84 PM: 100% eaten. A Bedtime Snack was accepted at 8:40 PM.- 4/14/26: 8:00 AM: 100% eaten; 12:04 PM: 50% eaten; 9:21 PM: 25% eaten. A Bedtime Snack was offered and refused at 9:21 PM.- 4/15/26: 9:25 AM: 100% eatenResident #702 did have a task titled, Bladder Continence and Toilet Use which did not include amount of urine output. Task documentation specified if the Resident was continent or incontinent, self-performance of toileting activities and amount of toileting assistance provided. Review of progress not documentation in Resident #702's EMR revealed a Nursing/Clinical note dated, 4/12/26 at 2:52 PM which specified, Patient is alert x1 and resting in Geri chair at the nurses' station. Patient is nectar thick and a feed.Further review of documentation in Resident #702's EMR revealed the following: - 4/15/26 at 5:50 PM: Nursing/Clinical. Resident appeared to be lethargic/ hypotensive (low blood pressure) / bradycardic (low heart rate) message to (HCP). resident needs transport to (Hospital). - 4/15/26 at 6:10 PM: SBAR/Change in Condition. bradycardia/hypotensive. Most Recent Blood Pressure. 84/48 (low) . Pulse 52 (low) (4/15/26 at 5:39 PM) . Most Recent Blood Glucose: 98 (normal) 5/10/26 at 8:58 AM. Other: Lethargic. Functional status Evaluation 10. Describe functional status changes: 1. Needs more assistance with ADLs 2. General weakness 3. Decreased mobility. 5. Swallowing Difficulty. functional status signs or symptoms: lethargy/weakness. Cardiovascular Evaluation. cardiovascular changes. Inability to stand without severe dizziness or light headedness. bradycardia/hypotension. Genitourinary Evaluation. changes. Decreased urinary output over 1-2 days. - 4/16/26 at 7:26 AM: (Authored after Resident #702 was transferred to the hospital) Physician/Practitioner Progress Note. Patient seen on 04/15/2026 at 11:00 a.m. per staff is not really consistently eating drinking much they tried to feed (Resident #702) oral intake is limited. Labs reviewed sodium is 150 8 due to poor oral intake. overall oral intake is quite poor overall prognosis poor. An interview was completed with the Director of Nursing (DON) on 5/5/26 at 1:52 PM. The DON was asked if Resident #702 was admitted to the facility for skilled services and verbalized they were. When queried regarding the lack of daily skilled nursing assessment documentation, the DON responded that the daily skilled nursing assessment documentation is related to billing and reimbursement and does not need to be completed daily by nursing staff. An interview was completed with Licensed Practical Nurse (LPN) G on 5/5/26 at 2:19 PM. LPN G was asked if they admitted Resident #702 to the facility and confirmed they did. When queried Resident #702's cognition and communication, LPN G stated, (Resident #702) was A & O (alert and orientated) X 3 (person, place, time). LPN G continued, (The Resident) was able to communicate. They could give a yes or no. When queried regarding Resident #702's diet, eating and drinking, LPN G stated, I didn't feel comfortable until they were seen by OT (Occupational Therapy). With further inquiry, LPN G stated, (Resident #702) was on a special diet- like mashed potatoes and gravy and thickened liquids. When queried regarding a diet order not being placed in the EMR, LPN G did not (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide an explanation. When queried what the Resident ate as a bedtime snack if they did not have an order placed for a diet, LPN G responded that a paper slip is completed and sent to the kitchen. When asked if Resident #702 was seen by OT on 4/11/26 prior to eating, as they said they were uncomfortable, LPN G replied, No. No further explanation was provided. When queried, LPN G verbalized that was the only time they cared for Resident #702 during their stay at the facility. On 5/5/26 at 3:00 PM, an interview was conducted with Certified Nursing Assistant (CNA) H and CNA L. When asked, both staff verbalized they had provided care to Resident #702. When queried regarding the level assistance Resident #702 needed for ADL care, CNA H responded, (Resident #702) was mostly up in the Geri chair (specialized, reclining wheeled chair with cushioned seats and solid footrest area for individuals with limited mobility) so we could monitor them. CNA H verbalized they were a Total check and change indicating the Resident was incontinent and dependent upon staff for toileting. When queried regarding Resident #702's oral intake and diet, CNA L stated, (Resident #702) would spit it out. When asked if they were talking about food, CNA L responded that Resident #702 did not seem to like the pureed food they were provided. When queried regarding drinking, CNA L replied, It would kind of run out of their mouth. When asked if the Resident drank any fluids, CNA L reiterated that fluids would run out of the Resident's mouth. When asked if they were working when Resident #702 was transferred to the hospital ER on [DATE], CNA H responded they were. When queried what happened, CNA H stated, (Resident #702) was in the Geri chair and probably an hour into the shift, (the Resident) wasn't responding. CNA H was asked what time their shift starts and replied, Two (2:00 PM). When queried how long after staff identified Resident #702 was not responding that they were sent to the hospital, CNA H revealed they were unsure. When queried if they noticed any other changes in Resident #702 prior to the Resident not responding, CNA L stated, Resident #702) slept a lot. Review of staffing/schedule sheets during Resident #702's stay at the facility revealed CNA L worked with Resident #702 on 4/11/26, 4/12/26, and 4/14/26 and CNA H worked with the Resident on 4/11/26 and 4/15/26. An interview was completed with Unit Manager Registered Nurse (RN) D on 5/5/26 at 3:38 PM. When queried if Resident's should have diet orders in the EMR, RN D verbalized they should. RN D was then asked to review Resident #702's EMR for a diet order. After reviewing Resident #702's HCP orders, RN D stated, Ordered on 4/13/26. When queried why Resident #702 did not have a diet order until 4/13/26 when they were admitted on [DATE], RN D was unable to provide an explanation. RN D then stated, There is a kitchen dietary slip that they (nursing staff) send out. When queried if the Resident's diet should be on the Kardex, so staff are aware of any special dietary requirements/restrictions, RN D replied, It should definitely be on the Kardex. Resident #702's Kardex was reviewed with RN D at this time. When queried how staff knew that Resident #702 needed thickened beverages, prior to Monday 4/13/26 when it was not ordered, included on the care plan and/or Kardex, RN D replied that the information should be passed from staff to staff in report. With further inquiry, RN D verbalized they had no way to show what Resident #702 received related to oral intake and stated, I get what you're saying. On 5/5/26 at 6:00 PM, an interview was completed with RN M. When queried regarding Resident #702, RN M verbalized they cared for the Resident on the on midnight shift the day they were admitted . When queried regarding Resident #702's diet and oral intake, RN M responded that they did not recall. A review of Resident #702's hospital Discharge Instructions, Orders, and Medication documentation scanned in the EMR did not include a diet order. A follow-up interview was completed with Witness A on 5/5/26 at 6:30 PM. When queried regarding Resident #702's diet at the hospital, Witness A responded that the Resident was on a mechanical soft diet. Witness A verbalized Resident #702 had to be fed and revealed they fed them the day they went to the hospital. Witness A stated, They are their whole plate at the hospital and drank without difficulty. Review of staffing/schedule sheets revealed LPN N was assigned to Resident #702 on 4/15/26 during the day shift. Resident #702 was transferred to the hospital at 6:46 PM.An interview was conducted with LPN N on 5/6/26 at 9:25 AM. When queried if they recalled Resident #702, LNP N voiced they did and confirmed they were the Resident's assigned day shift (6:00 AM to 2:00 PM) nurse (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 4/15/26. When asked how the Resident was during their shift, LPN N replied, (Resident #702) was very tired. They set up in the hall in the Geri chair. LPN N stated, The girls (CNA staff) tried to get (Resident #702) up to clean them up and they could barely stay awake. When asked if that was normal for Resident #702 to be that lethargic during the day, LPN N revealed that was the first time they had taken care of Resident #702 and they did not know. When queried how they determine what a resident's normal is when it is their first time caring for a resident, LPN N revealed they go off of what is charted and what they receive in report. Documentation from Resident #702's EMR was reviewed with LPN N at this time. When asked how they determine if there is a change from a resident's baseline with so little documentation in the EMR, LPN N replied, You don't. I guess you go off of what you get in report. LPN N was asked if they were informed of anything abnormal during report, LPN N responded they had not. When queried if Resident #702 ate during their shift, LPN N replied, They ate a few bites and would fall asleep. When queried if the Resident drank, LPN N stated, Maybe a few sips, maybe. (Resident #702) was not eating or drinking. When queried regarding task documentation in the EMR specifying Resident #702 ate 100% of their meal, LPN N stated, (Resident #702) did not eat 100%, no way. When asked if they assessed the Resident for signs/symptoms of dehydration, LPN N replied, No. Review of staffing/schedule sheets revealed CNA K was assigned to Resident #702 on 4/11/26 and 4/12/26 on the midnight shift.On 5/6/26 at 10:07 AM, an interview was conducted with CNA K. When queried if they assisted Resident #702 to eat, CNA K replied, No. CNA K was then queried regarding how Resident #702 drank and stated, It was in a straw. When asked if Resident #702 had thickened liquids, CNA K replied, I do not think (Resident #702) was on thickened liquids. CNA K was then asked how they know if a resident is on a special diet such as pureed and/or if they need thickened liquids, and replied, I check the Kardex. CNA K verbalized any special diets are listed on the Kardex and stated, That is for sure.Review of staffing/schedule sheets revealed CNA I was assigned to Resident #702 during the afternoon shift on 4/12/26. An interview was completed with CNA I on 5/6/26 at 10:25 AM. When asked, CNA I verbalized they remembered Resident #702. When asked if they assisted the Resident to eat, CNA I replied, (Resident #702) wouldn't really eat themselves, you would have to feed them. When asked how the Resident ate, CNA I replied, (Resident #702) didn't really like the pureed food but really liked pudding. When asked how Resident #702 did with drinking, CNA I stated, Didn't like the straw and would try to take off the lid. CNA I continued, If I gave it (beverage) to them with the spoon, they would drink it. An interview was completed with Family Member Witness B on 5/6/26 at 10:55 AM. When asked, Witness B verbalized they visited Resident #702 at the facility on Monday morning (4/13/26). When queried how Resident #702 was doing, Witness B stated, (Resident #702) was OUT of it. I tried talking to them and they didn't respond at all. When queried if that was a change from how they had been doing, Witness B replied, On Saturday in the hospital (Resident #702) knew we were talking to them and said a couple words. They could respond. Witness B expressed how upset and shocked they were to see (Resident #702) in that condition after the improvements they had made in the hospital. When asked if the Resident had a beverage in their room and/or near them, Witness B stated, (Resident #702) didn't have anything. Witness B was asked if they expressed their concerns to facility nursing staff and responded they told them that Resident #702 was more tired and less responsive than they had been in the hospital. Witness B articulated they are not a health care professional and counted on the facility nursing staff to care for Resident #702. An interview was completed with Therapy Director C on 5/6/26 at 11:00 AM. Director C was asked when Resident #702 was evaluated by therapy service disciples and stated, OT on Saturday (4/11/26), ST (Speech Therapy) on Sunday (4/12/26), and PT (Physical Therapy) on Monday (4/13/26). A review of the Evaluations was completed with Director C and revealed the following:- 4/11/26: OT Evaluation and Plan of Treatment. Patient Goals: become stronger and return home. Functional Skills Assessment. Eating = Substantial/maximum assistance . The evaluation further detailed Resident #702 required substantial/maximum to total assistance for hygiene, bathing, and dressing. - 4/12/26: SLP (Speech-Language Pathologist) Evaluation and Plan of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatment. Chart Review. Current Intake. Moderately Thick Drinks. Pureed Foods. Patient needs assistance feeding self = yes. Recommendation. Moderately thick (liquids). Pureed (foods). - 4/13/26: PT Evaluation and Plan of Treatment. Transfers. Dependent. Hoyer lift. When queried how Therapy recommendations are communicated to nursing staff, Director C responded that recommendations are compiled and emailed to nursing after all therapy disciplines have evaluated a resident. Director C was informed Resident #702 did not have a diet order in the EMR until 4/13/26. When asked if ST puts diet orders in the EMR after evaluating a resident, Director C responded that they do not. When queried regarding the ST Evaluation indicating Resident #702 was on a pureed diet with nectar thickened liquids prior to their evaluation, Director C indicated the diet recommendations must have came from the hospital. Review of the scanned hospital referral information in Resident #702's EMR was completed with Director C at this time. A Speech Therapy (ST) evaluation and recommendations dated 4/6/26 was located in the referral packet. This evaluation specified, Diet Consistency Recommendation: NDD3 (National Dysphagia Diet level 3- moist foods in bite sized pieces that are easy to chew and swallow). Liquid Viscosity Recommendation: Thin (normal with no thickening) . Supervision Swallow Recommendation: 1:1. Details. Promote below swallow precautions and encourage intake. Upright 90 degrees. Alternate liquids/solids, Slow rate; swallow between bites, small bites of food, small sips of liquid. When queried regarding the ST evaluation recommendations not corresponding with nursing note documentation and ST prior diet documentation, Director C confirmed the inconsistency and indicated they would review the Resident's EMR further. An interview was completed with ST P and Therapy Director C on 5/6/26 at 12:45 PM. When queried how they identify what diet a resident is currently on when completing an evaluation, ST P stated, I go off what modified diet they are on. When asked how they know what diet a resident is on, ST P replied, I look through the hospital discharge and talk to the nurses. If I can't find it, then I do an assessment. When queried if they recalled where they found Resident #702's prior diet information when they completed their evaluation, ST P replied, I don't. When queried if Resident #702 had a beverage when they evaluated them, ST P stated, I can't remember that. When queried what their diet recommendations were for Resident #702 were following their evaluation, ST P replied, Pureed diet and nectar thick (fluids) with feeding assist. Aspiration precautions and supervision. When queried if they recommended a specific cup and/or straw use, ST P replied, Could have been just a spoon. I don't really do the adaptive equipment. Director C then voiced that OT makes recommendation related to adaptative equipment and stated, OT said max assist for feeding. On 5/6/26 at 1:20 PM, an interview was conducted with the DON. When queried regarding Resident #702 not having a diet order and/or care plan/Kardex related to modified diet needs, the DON stated, I don't have an answer for you. When queried regarding documentation of dietary intake without a HCP provider order as well as lack of documentation of fluid intake, the DON did not provide further explanation. When queried regarding lack of clear documentation of Resident #702's urine output and monitoring for signs/symptoms of dehydration due to the Resident's increased risk, the DON indicated facility staff document by exception. When queried how to know if staff were assessing the Resident for signs/symptoms of dehydration when daily assessments were not completed, an explanation was not provided. Review of requested external hospital medical records for Resident #702 revealed an ED Note/Physician / Provider dated 4/15/26 at 11:01 PM. The note detailed, Per EMS, patient coming from facility where he was noted to be altered for at least the last couple hours. more altered compared to the last neurology note from 4 days ago. Multiple diagnoses considered including hypotension, dehydration, sepsis. Final Diagnosis: AMS (altered mental status) . AKI (Acute Kidney Injury).Note: Dehydration, sepsis (body's response to infection causing inflammation in the body), and heart failure are common causes of AKI. Review of laboratory testing results from the ED hospital records revealed the following results on 4/15/26 at 7:43 PM:- BUN (Blood Urea Nitrogen- blood test which measures the amount of urea nitrogen in the blood and is used to assess for kidney function): 38.2 mg/dL (milligrams/decaliter) (Elevated - normal is between 9 and 27 mg/dL. Elevated levels (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated kidney dysfunction and/or dehydration)Note: On 4/11/26 at 5:34 AM, Resident #702's BUN was 17.6 mg/dL prior to discharge to the facility. - Creatinine (waste product filtered by kidneys and excreted in urine, used as an indicator of kidney function): 1.6 mg/dL (High [normal range between 0.6 and 1.5]- elevated levels indicate issues with kidney function)Note: Hospital records showed Resident #702's creatinine level was 0.8 mg/dL on 4/11/26 at 5:34 AM prior to discharge to the facility. - BUN/Creat Ratio (BUN-to-creatinine ratio- blood test used to assess kidney function and hydration): 23.88 (High [normal between 10 and 20]- elevated resulted often indicates dehydration and/or kidney dysfunction).Note: Hospital records showed Resident #702's BUN was 22 mg/dL on 4/11/26 at 5:34 AM prior to discharge to the facility. - Sodium level (test to measure the amount of sodium in the blood used to evaluation hydration and kidney function): 148 mmol (millimoles)/L (liter) (High - commonly caused by dehydration- normal range is 135 to 145 mmol/L)Note: Hospital records showed Resident #702's Sodium Level was 145 on 4/11/26 at 5:34 AM prior to discharge to the facility. - WBC (White Blood Cell - blood test used to detect infection or immune system response): 17.57 (High -normal 4.50 to 10)Note: Hospital records showed Resident #702's WBC was 8.78 on 4/11/26 at 5:34 AM prior to discharge to the facility. Per the ED documentation, Resident #702's family made the decision to admit the Resident to Hospice services at the hospital. Resident #702 was admitted to the hospital on [DATE] at 2:29 AM with orders for comfort care only. Review of facility provided policy/procedure entitled, admission Assessment and Follow Up: Role of the Nurse (Revised: 1/26) revealed, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission. 8. Conduct a physical assessment, including the following system. 12. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The following information should be recorded in the resident's medical record. 3. All relevant assessment data obtained during the procedure. 5. Orders obtained from the Physician. Reporting: 1. Notify the supervisor and the Attending Physician of immediate needs that the resident may have. Review of facility policy/procedure entitled, Charting and Documentation (Reviewed: 7/2025) revealed, Services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of facility provided policy/procedure entitled, Urinary Incontinence - Clinical Protocol (Reviewed 4/2026) did not include documentation and/or assessment/monitoring of urinary output.