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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235217	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Bloomfield Hill	2975 N Adams Road Bloomfield Hills, MI 48304

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2711600 Based on observation, interview, and record review, the facility failed to ensure one (R5) of one resident reviewed for accommodation of needs had an appropriate call light that they were able to use. Findings include. A review of a complaint submitted to the State Agency revealed an allegation that R5, a resident who was bed bound did not have a proper call light. The complaint further noted R5 was unable to utilize her hands to activate the call light and it was difficult for staff to know when she needed assistance. On 1/12/26 at 10:20 AM, R5 was observed lying in bed with their head leaned over to the left side. A standard push button call light was observed clipped to R5's blanket. At that time, R5's family member was present and was asked if R5 was able to use the call light and they were not sure. On 1/14/26 at 10:00 AM, R5 was observed lying in bed with their head leaned over to the left side. A standard call light was observed clipped to R5's blanket. At that time R5 was asked if they were able to press the call light button and they slightly shook their head to indicate they could not. On 1/14/26 at 10:12 AM, an interview was conducted with Unit Manager, Registered Nurse (RN) 'B'. When queried about whether R5 was able to use a standard push button call light, RN 'B' reported she could. At that time, an observation of R5 was made with RN 'B'. RN 'B' asked R5 if they could hold the call light and R5 said she could not. RN 'B' attempted to put the call light into R5's hand and was unable to. RN 'B' said R5 could not hold the call light and said she would need to be assessed for a different type of call light. On 1/14/25 at 10:30 AM, an interview was conducted with the Director of Nursing (DON). The DON reported if staff noticed a resident was unable to use a standard call light, they should be assessed for an appropriate call light. A review of R5's clinical record revealed R5 was admitted into the facility on 9/10/25 with diagnoses that included: contractures, functional quadriplegia, and muscle wasting and atrophy. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R5 had unclear speech, severely impaired cognition, and was dependent on staff for all activities of daily living. A review of a facility policy titled, Call Light Accessibility and Timely Response dated 8/16/23 revealed, in part, the following, .Each resident will be reviewed for unique needs and preferences to determine any special accommodation that may be needed for the resident to utilize the call light system .

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: 235217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026

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Optalis Health & Rehabilitation of Bloomfield Hill	2975 N Adams Road Bloomfield Hills, MI 48304

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. This citation pertains to Intake 2711600. Based on observation, interview and record review, the facility failed to maintain a homelike environment for three residents (R5, R9 and R85) of three reviewed for environment. Findings include:On 1/12/26 at approximately 11:03 AM, during an initial tour of the facility, R9 was observed lying in bed. There were several items of garbage all of the floor and the wall across from their bed was splattered with a brown substance. A second observation was made on 1/12/26 at approximately 2:10 PM and the room remained the same. On 1/12/26 at 10:20 PM, an observation of R5 and R85's room was conducted. The floor on both side of the room were littered with trash and debris and appeared as if it had not been mopped. R5's over bed table appeared dirty and discolored. R5's nightstand was observed with multiple dried spots of tube feeding formula on the top and dried formula that had dripped down the front of the nightstand. R85's overbed table appeared dirty and sticky. R5's family member was asked about whether the room was typically cleaned and R5's family member pointed to the trash on the floor and shrugged. On 1/13/26 at 11:15 AM, an observation of R5 and R85's room was conducted with Maintenance Director 'F'. At that time, the floor, nightstand, and over bed tables remained in the same condition as mentioned about. Maintenance Director 'F' acknowledged the condition of the room and said it needed to be cleaned and R5's overbed table needed to be replaced. A review of a facility policy titled, Homelike Environment, dated 9/21/23, revealed, in part, the following, .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment .

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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** There are two deficient practice statements. Deficient Practice Statement (DPS) #1. This citation pertains to Intake 2703853.Based on interviews and record reviews the facility failed to complete accurate assessments, document accurate vitals in the medical charts, complete labs as ordered, administer medications/intravenous fluids as ordered, and report accurate assessments to the Physician for timely treatment, care and/or transfer to a higher level of care, for three (R's 122, 99 and 4) of four residents reviewed for a change in condition.Findings include: R122 A review of a complaint submitted to the State Agency (SA) documented a concern of the facility's negligence that resulted in the death of R122. A review of the hospital record Discharge Summary dated 12/5/25 at 8:55 PM, noted in part . presented for a few days of decreased oral intake, fatigue, lethargy. having poor oral intake and coughing when attempting to eat. Per wife, he was prescribed diltiazem on 11/29 for documented tachycardia. Per EMS (emergency medical services) note, patient was hypotensive 97/67, HR (heart rate) 140s. On admission, he was hypotensive 79/56, HR 138. T 40.3 C (104.54 degrees Fahrenheit), Sp02 99% on 6L (liters) NC (nasal cannula). He was given sepsis bolus LR (lactated ringers) 2.1 L, vanc (vancomycin) and Zosyn (intravenous antibiotics) were started and pt (patient) was admitted for further workup. WBC (white blood cell) 14.6. Comfort care measures after talking to family. Pt expired at 20:55 (8:55 PM). Family notified at bedside. A review of the medical record revealed R122 was initially admitted to the facility on [DATE] with a readmission date of 7/29/25 with diagnoses that included: dementia, seizures and dependence on wheelchair. A Minimum Data Set (MDS) assessment dated [DATE], noted that R122 was . rarely/never understood). R122 was dependent on staff for all Activities of Daily Living (ADLs). A review of the progress notes documented in part: On 11/29/25 at 3:27 PM, a Nursing note documented in part . Nurse was checking resident's vitals as per ordered, noticed elevated HR (heart rate), nursed notified that to doctor and received verbal order for medication, ordered followed. On 12/1/25 at 8:28 PM, a Nursing note documented in part . Resident wife wants provider to notify her. Wife also had c/o (complaint of) nail bed being discoloration. Writer did assessment. Resident fingers were cold. Resident fingers didn't appear to have discoloration. Writer informed unit manager of wife concerns. Resident appetite poor today. Fluids encouraged. A review of a Nurse Practitioner (NP) consultation dated 12/2/25, documented in part . Temp (temperature) 97.7, BP (blood pressure) 168/89, heart rate 77, SpO2 96% . Family at the nurses station requesting appetite stimulant. Reports patient is having a decreased appetite. Nursing reports patient is pocketing food in his cheeks and not swallowing. Respiratory: Clear to auscultation, symmetric, No respiratory distress. A Nursing note dated 12/2/25 at 6:50 PM, documented in part . vitals are taken after wife/guardian alerted on shift nurse, vitals SPO2 saturation was declining from 94% go 91%, nurse also heard on (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

lower lobe, resident was having SOB (shortness of breath), on shift nurse notified doctor and DON (Director of Nursing) changing condition, as per guardian wife request, nurse received order to send resident to the hospital from doctor.

A review of the vitals for 12/1/25 at 8:36 AM, recorded the following: Temp 97.7, BP 168/89, Pulse 77, and SpO2 96% on room air.

These are the same values noted in the NP consultation on 12/2/25.

An interview conducted with the complainant on 1/13/26 at 3:20 PM, revealed in part . The nurse came back running and called the doctor and the doctor said that no one is leaving my facility and the wife called 911.

An interview was conducted with R122's wife on 1/13/26 at 5:45 PM. R122's wife was asked if they could recall the incident that led to their husband being transferred to the hospital on [DATE]. R122's wife stated they arrived at the facility around 5:45 PM that evening and noticed that R122 did not look well and they wanted R122 transferred to the hospital. R122's wife stated they notified the nurse who replied they would call the Physician. R122's wife stated the doctor was yelling at the nurse and was threatening their job is they sent the resident out to the hospital. The wife stated they demanded as R122's guardian to send the resident to the hospital and the resident was then transferred. R122's wife stated prior to being transferred the nurses were attempting to obtain vitals and the blood pressure machines were not working properly. The wife stated they had taken pictures that was verified by the date and time that staff had obtained the vitals. A picture of the facility's blood pressure machine was reviewed. The photo had the properties of 12/2/25 at 6:17 PM, that showed a BP of 215/160. The wife admitted it took a while for the staff to send the resident out to the hospital due to the staff waiting for the approval to transfer the resident from the Physician.

On 1/13/26 at 4:30 PM, a telephone interview was attempted with Registered Nurse (RN) S (the nurse assigned to R122 the shift they were transferred to the hospital) and was unsuccessful. A message was left for RN S to return the call.

On 1/14/26 at 9:39 AM, RN S returned the call for an interview. When asked about the change in condition with R122 on 12/2/25 that required a transfer to the hospital, RN S stated they along with the unit manager took the resident vitals, notified the doctor and sent the resident out to the hospital. When asked how they became aware of the change in condition for R122, they stated R122's wife had informed the unit manager. RN S stated they were on the second floor helping another nurse with something. RN S stated when they came back down to the floor, they along with the unit manager obtained R122's vitals. RN S was asked about the picture provided by R122's wife that noted the resident BP to be 215/160 and RN S confirmed they had received that reading, however stated they obtained two of the facility's blood pressure machines and both were given two different readings. When asked why the 215/160 was not documented in the residents chart, RN S stated they thought it was an unbelievable reading and felt that the reading wasn't accurate due to R122's contracted body. When asked if either of the nurses had taken R122's vitals manually to confirm the abnormal value, RN S stated they did not. The vitals documented in the medical record was reviewed with RN S at the time of the change of condition that noted no temperature to have been obtained, a blood pressure of 100/61 (manual), a pulse of 79 (manual), respiration of 22 breath/min and pulse oxygen saturation of 91% on room air all at 6:31 PM. RN S was asked why they did not obtain a full set of vitals that included a temperature and RN S did not have a response. RN S then stated that R122 was declining and their oxygen saturation had dropped down to 89, heart rate and blood pressure was abnormal. When asked why the

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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

medical record did not reflect the true values of the decline, RN S replied . I wasn't sure if I should document it, if they weren't true values. RN S was then asked what the Physician directive was when they notified them of R122's condition. RN S stated the Physician told them they were not sending the resident out with a 94% oxygen saturation. When asked what exactly it was that they reported to the Physician, RN S stated they informed the Physician that R122's . heart rate is all over the place, 02 stat (oxygen saturation) was 94% and he looks very distress and blood pressure is high. RN S stated they were unsure if they called the Physician back to inform them of their declining oxygen saturation but was told by the Physician that if R122 declines, to send the resident out. RN S stated the Physician verbalized that if they (RN S) were the one to send R122 out without the family to have requested it, they (RN S) would be in big trouble.

A review of the recorded vitals from 11/29/25 to 12/2/25 documented the only abnormal reading of a blood pressure of 168/89 on 12/1/25 at 8:36 AM.

A review of a EMS Ambulance Form dated 12/2/25, documented the following in part . Primary impression Sepsis/Septicemia. Signs & Symptoms- Fever, Hypotension, Tachycardia. responded emergency. of difficulty breathing. pts (patient) oxygen level was low and had an elevated heart rate. family sts (states) he is more lethargic than normal. initial assessment of lung sounds found rhonchi in all fields. Initial 02 saturation was 80% on room air. found sinus tachycardia at 140 bpm (beats per minute). found respirations 35-40. fluid bolus given for hypotension. transported priority 1. Oral temperature was assessed and found 101.4.

The facility nurses failed to obtain, document and report to the Physician accurate assessments of R122's change in condition.

A review of the hospital records revealed the following:

A Emergency Medicine consult dated 12/2/25 at 7:31 PM, . Triage Complaint: Shortness of Breath. presenting to the emergency department over concerns. profoundly tachycardic in the 140s pre-hospital, and relatively hypotensive with systolic pressures in the 90s. He was started on IV (intravenous) fluids and transported to the ER (emergency room) for further evaluation. Tachycardia present.

Review of the medical records revealed R122 was admitted to the Medical Intensive Care Unit at the hospital.

R4

On 1/12/26 at approximately 3:03 PM, a review of R4's clinical record was reviewed and revealed the resident was initially admitted to the facility on [DATE]. Their last readmission to the facility was 1/9/2026 following a hospital stay from 12/30/25 through 1/9/26. R4 had diagnoses that included: coronary heart disease, paranoid schizophrenia, type II diabetes and psychotic disorder. A review of the resident's Minimum Data Set (MDS) noted a Brief Interview for Mental Status (BIMS) score of 14/15 (intact cognition).

Continued review of R4's clinical record revealed the following:

12/26/25: Nursing Notes: .writer was notified by CNA (Certified Nurse Assistant) that resident had vomited her am Medications, writer assessed resident and resident c/o (complains of) upset stomach and not feeling well. Resident did not eat breakfast, nor lunch, resident had nausea and vomiting 2x

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	today . 12/26/25: SBAR (Situation, Background, Assessment, Recommendation): .Change in Condition: .Nausea and vomiting .Recommendations: New Testing Orders .Blood Tests . 12/27/25: Lab Results: CBC/Diff (Blood test that provides a detailed breakdown of blood cells): .Collection date: 12/26/25 Reported date: 12/27/25 (7:07 AM) .Results: WBC (white blood count) 15.4 (high) .RBC (red blood count) 3.88 (low) HGB (hemoglobin) 11.4 (low) . 12/27/25: SBAR (late entry): .Change in Condition: Bleeding other that GI (gastrointestinal) .Recommendations: New Testing Orders: blood test . *Blood Test had already been collected on 12/26/25 see above. 12/27/25: Laboratory: Lab results placed in Dr.(Doctor) log and faxed to Dr. NN. Further review of the medical record revealed no documents that indicated the lab results were read by Dr. NN. 12/28/25 (12:03 PM): Nursing Note: .Resident nose was bleeding .Ordered a BCB for Monday . 12/30/25: Physician Team Progress Notes: .Following to review repeat venous Doppler . 12/30/25: SBAR Notes: .Change in Condition: Altered mental status Functional decline .At the time of evaluation resident/patient vital signs .Blood Pressure 104/66 .altered level of consciousness .Recommendation: send resident hospital .New Testing . 12/30/25 (11:09 AM): Nurse-Transfer to Hospital Summary: Resident being sent to hospital .experiencing changes . (Authored by Nurse P). 12/30/25: Blood Pressure Summary: The last Blood Pressure (BP) record noted R4's BP at 104/66. There were no additional BP notes recorded on 12/30/25. (recorded by Nurse P) EMS (emergency medical services): .Pt (Patient) transferred 12/30/25 .11:34 AM .the patient has is experiencing hypotension, which has persisted for 3 hours . presents with generalized weakness and hypotension . PT nurse states she had a pressure of 80/59 prior to arrival and states she was throwing up last night . Hospital Records (12/30/25-1/9/26): .History of Present Illness: .presents with dehydration and low blood pressure. She was sent from her extended care facility due to not eating or drinking for the past week, resulting in dehydration and low blood pressure. Her initial blood pressure was recorded in the fifties, and upon arrival, it was seventy-six over forty-six .She experienced vomiting and was unable to keep food down .her potassium level was noted to be three .Assessment and plan: Dehydration and hypotension . On 1/14/26 at approximately 2:39 PM, an interview was conducted with Nurse P. Nurse P reported that they are an Agency nurse and work in different areas in the building approximately three times per week. Nurse P was asked if they were familiar with R4 and their change in condition on 12/20/25. Nurse P reported that R4 was in activities and a staff person came to tell her that R4 did not seem herself. Nurse P recalled trying to take R4's BP with two different machines and recalled that one BP read low. Nurse P could not recall the BP level. When asked if they had been informed that R4 had experienced vomiting and bleeding the past few days, Nurse P reported that they were not aware and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted as an agency nurse not all information is provided. On 1/14/26 at approximately 2:47 PM, an interview and record review were conducted with the DON and ADON W and Corporate Clinical Support BB. All were asked about R4 and queried as to whether the 12/26/25 lab results were read and any further documentation related to R4's vitals. It was reported that it appeared the 12/26/25 labs were provided to Physician NN. On 1/14/26 at approximately 3:58 PM, a phone interview was conducted with Dr. NN. Dr. NN was asked if they had reviewed the labs obtained on 12/26/25 and if so, would they have made any additional orders based on the results. Dr. NN reported that they did not recall viewing the lab results and indicated that if they had, notes would have been placed in the resident's record. R99 A review of a hospital Discharge Summary dated 1/6/26, documented in part . Principle problem: Respiratory Failure. Procedures performed: Intubation, Arterial Line, Central Line. He was found unresponsive and required airway protection. On arrival, his Glasgow Coma Scale (GCS) was 3. He then developed VT (ventricular tachycardia) arrest, then shock requiring pressors. MICU (medical intensive care unit) was consulted for respiratory failure and shock. he was started on Zosyn after blood cultures were collected. He then experienced a ventricular tachycardia (VT) arrest lasting approximately 15-20 minutes, during which he was defibrillated seven times and received amiodarone and lidocaine. He had another episode of loss of pulse and was persistently hypoxic, requiring bagging. He was eventually started on levophed (intravenous vasopressure- used to treat severe hypotension), vasopressin (vasopressor used to treat severe hypotension), amiodarone infusion (intravenous treatment for severe, life threatening heart rhythm problems) and transferred to ICU (Intensive Care Unit). On further discussion. family decided on pursing a comfort care approach. Gift of life approached family regarding organ donation and family agreed. He was continued on pressor and ventilator support till the organ donation surgery, where his support stopped. and pronounced at 9:43 AM on 01/06/26. A review of the medical record revealed R99 was initially admitted to the facility on [DATE], with diagnoses that included: cerebral infarction, acute respiratory failure with hypoxia and hemiplegia and hemiparesis affecting the left side. A MDS assessment dated [DATE], documented Moderately impaired cognitive skills for daily decision making and was dependent on staff for all activities of daily living. Review of the progress notes revealed the following: On 12/28/25 at 12:11 PM, a Nursing note documented in part . Resident has change in condition audible fluid on lungs accompanied by cough. Residents bp (blood pressure) is elevated and has a low grade fever of 99.1. Tylenol administered per order along with 40mg (milligram) Lasix IM (intramuscular). Physician aware and family. On 12/29/25 at 7:26 AM, a Nursing note documented in part . BP 155/81, Pulse 101. On 12/30/25 at 7:27 AM, a Nursing note documented in part . Change In Condition. Shortness of breath. the resident started to present sob (shortness of breath), tachycardia, which may be caused by his poor healthy-medical history/conditions. Primary Care Provider responded with the following feedback. log into the dr. book, Dr. (doctor)/NP will come today to see the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/25 at 10:08 AM, a NP note documented in part . Chief Complaint: Acute respiratory failure multiple wounds, pneumonia. decreased responsiveness no verbal response. Makes eye contact slight left facial droop noted. diminished breath sounds bilaterally. Monitor 02 sat. Monitor vital signs. Monitor for signs of infection. On 12/30/25 at 2:18 PM, a Nursing note documented . tachypneic and tachycardic, NP notified, CBC and CMP (Comprehensive Metabolic Panel) was ordered, morning BP meds were held r/t (related to) vitals being outside of parameters. Review of the medical record revealed no results of the ordered CBC and CMP to have been completed. Review of the December 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR), noted the 12/30/25- 9 AM Lisinopril 40 mg (milligram) and the 9 AM Metoprolol 25 mg to be held. The parameters on the Metoprolol noted SBP (systolic blood pressure) < (less than) 100 or HR (heart rate) <60. A review of R99's blood pressure and heart rate that morning was documented the SBP (systolic or top number of blood pressure) to be 101 and the HR to be 67, which indicated they were not out of parameters as noted by the nurse. On 12/31/25 at 2:21 PM, a NP note documented in part . Chief Complaint: Tachycardia, tachypnea. diminished breath sounds. Temp 99.6. heart rate 114. sp02 98% on 3 L. Monitor 02 sat. Tachycardia 1 L normal saline IV fluid bolus. Labs pending. Monitor. Review of the December 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR), revealed no documentation of the IV fluid bolus to have been administered. On 1/2/26 at 3:55 PM, a Nursing note documented in part . observed the resident was lethargic and had a pulse of 129. MD (medical doctor), NP. notified. medication given as ordered. New order to increase metoprolol to 50mg. On 1/2/26 at 8:01 PM, a MD (Medical Doctor) note documented in part . Heart Rate: 125. Tachycardia- 1 L normal saline IV fluid bolus at 80 CC (cubic centimeters) an hour. Labs pending, Monitor. Increase metoprolol to 50 mg twice daily. Monitor 02 sat. Monitor CBC CMP. history of small ischemia infarcts. A review of the January 2026 MAR/TAR revealed the metoprolol 50 mg order was implemented and administered with the existing metoprolol 25 mg twice a day, with a total of 75 mg twice a day to have been administered. On 1/4/26 at 6:57 AM, a Nursing note documented in part . the resident sob (shortness of breath) at times, breathing treatment given with effectiveness, SPO2 increase from 88% to 92-93% NC 3L, the resident decrease sob.will continue to monitor. This note was documented by Registered Nurse (RN) JJ. On 1/5/26 at 7:57 AM, a Nursing note documented in part . monitoring for increase RR (respirations) and sob due to previous shift reported. during nighttime, noted the resident increase his breathing from 22-24/minute, breathing treatment given, spo2 between 90-93%/3L/NC, early morning lung sound diminished, crack? Noted, occasionally moaning, Tylenol 650 given through peg-tube for fever and pain, BP 153/75, 93, noted the resident RR increase to 26-30, SPO2 declining under 88%/NC/5L, breathing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment given, no improve, SPO2 continue to go down to less 85%, non-breathing applying with 15L, (Doctor name) have called, not get answer, left message regarding the situation, and also awaiting for call back, due to the resident rapidly change condition, 911 called, BP 168/89, HR 107, Spo2 <80% with non-breathing 15L, 911 arrived around 06:35am and transferred the resident to the hospital. This note was documented by Registered Nurse (RN) JJ. A review of the medical record revealed no orders or documentation for a breathing treatment to have been administered for the time of the above change of condition. A standing order for Tylenol 650 mg to be given four times a day, was signed for the 6:00 AM dose as administered. A review of an ambulance form dated 1/5/26, documented in part . Call. 01/05/2026 06:29:25. sitting up in bed unresponsive hyperventilating. Staff states they noted pt became less responsive and has a declining SPO2 for the past 20 min. Pt is unresponsive, GCS (Glasgow Coma Scale) 3 (unresponsive). Pt is on NRB (non-rebreather) @ (at) 15LPM (liters per minute). SPO2 59% RESPS 30. Rhales Bilat. (bilaterally). Placed NPA (nasopharyngeal airway) and began BVM (bag valve mask) ventilations w/15lpm 02. SPO2 increased to 77% . Transported P1 without incident or change in LOC (level of consciousness) Care transferred to staff. On 1/14/26 at 8:12 AM, RN JJ was interviewed and asked to recall the change of condition with R99 on 1/5/26 that caused the resident to be transferred to the hospital. RN JJ stated the resident was stable all night. They laid the resident down to complete a dressing change for their wounds. RN JJ stated the incident happened so fast. RN JJ stated they called the Doctor and left a message. RN JJ stated R99 did not improve so they called 911. RN JJ was asked what time and what breathing treatment they provided to R99, as there was no documentation of a breathing treatment to have been administered during the change in condition. RN JJ stated they could not recall what treatment they provided to the resident and was unsure of the time. RN JJ was asked if they had received a physicians order to provide the treatment for the change of condition and RN JJ stated they did not. RN JJ was asked how long they allowed the breathing treatment to be administered and how long they waited for the Physician to return their call before they decided R99 was not improving and still in respiratory distress. RN JJ estimated a 10 minute time frame. RN JJ stated the resident was hyperventilating and they obtained a pulse ox and called 911. RN JJ was asked to recall the actual value of the pulse ox that was obtained, as they documented that it was less than 85% and RN JJ could not recall. RN JJ was asked why they had not documented the actual values of R99's pulse ox, noting multiple times that the pulse ox was less than the value recorded and RN JJ did not have a response. RN JJ was asked the time they administered the Tylenol for the resident's fever during the chain of events and RN JJ stated it was a scheduled Tylenol and when they laid R99 down to do their dressing change they felt that they were . a little bit hot. RN JJ stated they did not check R99's temperature until they called 911. RN JJ stated they called the doctor, gave the breathing treatment without a physician order with no improvement and called 911. RN JJ was asked if the doctor ever called them back and RN JJ stated they did not. When asked the facility's protocol if they are unable to get a hold of the Physician and RN JJ stated there are no back up Physicians to call for emergencies. RN JJ was asked if they had notified the Physician on 1/4/26 when they noted the resident's pulse ox had decreased to 88% with shortness of breath and RN JJ stated they had not, because the resident improved with the breathing treatment. An audit for the actual administration times of R99's January 2026 medications was requested from the Director of Nursing (DON) and Corporate Clinical Support (CCS) BB on 1/14/26 at 8:42 AM. A second request was made for the audit of the administration times to the DON, Administrator and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CCS BB on 1/14/26 at 10:54 AM. On 1/14/26 at 10:59 AM, the DON replied the facility did not have access to provide the audit to the surveyor. On 1/14/26 at 11:18 AM, the survey team contacted the survey team manager to assist with obtaining the medical record audit for review. The Administrator informed the survey manager that the document would be provided. A third request was made at 11/14/26 at 11:48 AM, to the Administrator, DON CCS BB. At 12:31 PM, the Administrator responded that the facility did not have access to the times the medications were signed out. The email was forwarded to the survey team supervisor. A fourth request was made at 5:11 PM and a fifth request at 5:20 PM, to the Administrator, DON & CCS BB. The audit was not provided by the facility for review before the end of the survey. On 1/14/26 at 2:10 PM, Physician KK (the physician contacted by RN JJ on 1/2/26) was interviewed and asked if they recalled receiving a message on 1/2/26 regarding R99's change in condition, and Physician KK stated they could have but could not necessarily recall. Physician KK read RN JJ 's note regarding the Physician to not have returned the call and asked the facility's protocol if the nurses' are unable to reach the Physician during an emergency. Physician KK stated their voicemail message verbalizes if they are unable to get ahold of them to call the Administrator and Director of Nursing, who will then get ahold of the Physician based on the severity of the situation. Review of a facility policy titled Change in Condition dated 8/9/23, documented in part . The nurse will notify the. resident's physician/practitioner. when there is. A significant change in the resident's physical. status, such as deterioration which includes life-threatening conditions or clinical complications. A need to alter the resident's medical treatment. The nurse will document in the resident's medical record information relative to the resident's change in medical. assessment, notifications, interventions, and response. No further documentation was provided by the end of the survey. Deficient Practice #2 Based on observation, interview and record review the facility failed to ensure hospice communication/care was provided and appropriately documented for one (R4) out of two residents reviewed for hospice. Findings include: On 1/12/26 at approximately 10:47 AM, R12 was observed lying in bed. The resident was alert but very confused and could not answer most questions asked. A review of R12's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Anorexia, Type II diabetes and dementia. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 0/15 (severely cognitively impaired). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order dated 8/27/24 read: Admit to (name redacted) Hospice. A review of R12's care plan noted: Focus: Hospice.Resident is at risk for grief, withdrawal, depression or anxiety.Interventions:.Collaborate care with hospice company to meet resident's needs.(12/4/2025)).HOSPICE VISITS-specify days and services provided 8/30/24). On 1/13/26 at approximately 12:01 PM, Registered Nurse (RN) EE was asked if they knew where any Hospice communication documents were located. RN EE was able to locate a thin binder near the nurse's station. The binder documents did not include the names and dates of the hospice care representatives that were visiting R12. On 1/14/26 at approximately 3:47 PM, an interview and record review of the binder were conducted with the Director of Nursing (DON) and Corporate Clinical Support (CCS) Nurse BB to determine the care and workers Hospice was providing, CCS Nurse BB made a call to the Hospice company. Hospice told CCS Nurse BB that R12 gets services from both a Nurse and a Certified Nursing Assistant (CNA) one time per week. The names of the care givers were provided. Both the Surveyor and CCS Nurse BB went to review the sign-in-sheets with Front Desk GG. Staff GG was not able to find any sign-in sheets for Hospice CNA for the past three weeks. CCS Nurse BB reported that it would be in the best interest of R12 to obtain new Hospice services as they were not performing necessary visits for R12. The facility policy titled, Hospice (dated 3/20/24) was reviewed and documented, in part, the following: .The purpose of this policy is to ensure Hospice services are available to residents at the end of life.In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness.provide the facility with the most recent hospice plan of care specific to each resident.communicating with the hospice provider and documenting such communication to ensure that the needs of the resident are addressed.Ensuring the facility is communicating with hospice representatives.Ensuring the hospice information is available within the facility.

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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 2690703. Based on observation, interview, and record reviews the facility failed to ensure interventions and treatment were implemented and/or applied consistently for two (R's 120 & 4) of four residents reviewed for pressure wounds. Findings include:R120 On 1/13/26 at 9:52 AM, an observation of R120's feet revealed white gauze bandages wrapped on both feet and dated 1/10. R120 stated the nurse is supposed to change their feet dressings before they were to be discharged that day. A review of the medical record revealed R120 was admitted on [DATE], with diagnoses that included: end stage renal disease, moderate protein-calorie malnutrition dependence on dialysis, and prediabetes. A review of the physician orders revealed the following: Cleanse left heel with wound cleanser, apply moist betadine gauze apply to left heel with abd (abdominal) pad and wrap with kerlix. Every night shift every Mon (Monday), Wed (Wednesday), Fri (Friday) for DTI (Deep Tissue Injury). Cleanser right lateral ankle with wound cleanser, apply medihoney, apply abd pad and wrap with kerlix. Every night shift every Mon, Wed, Fri for pressure ulcer. A review of the January 2026 Treatment Administration Record (TAR) revealed both treatments to the left heel & right lateral ankle was signed off as completed on 1/9/26 (despite the dressings to have been dated 1/10). Further review of the January 2026 TAR revealed the facility staff failed to complete the treatment ordered to both the left heel & right lateral ankle on 1/12/26. On 1/13/26 at 11:00 AM, Licensed Practical Nurse (LPN) G was asked to accompany the surveyor to R120's room. LPN G observed both feet dressings and verified the date of 1/10. LPN G was asked about the missed treatment on 1/12/26 and stated they were unsure whose responsibility it was to complete the treatment for R120 and was unsure on why it was not completed. LPN G stated they would ensure the treatment would be completed for R120. On 1/13/26 at 11:03 AM, Unit Manager (UM) HH was interviewed and asked about the missed treatment on 1/12/26 for R120 left heel and right lateral ankle. UM HH stated they understood the concern and will make sure the treatment gets done for R120. A review of a facility policy titled Skin and Wound Guidelines dated 3/20/24, documented in part . Identify prevention techniques and interventions to assist with the management of pressure injuries and skin alterations. Treatments are ordered by the medical practitioner. the goal for prevention and/or treatment, and individualized interventions to address the resident's specific risk factors and the plan for reduction of risk. No further explanation or documentation was provided by the end of the survey. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/12/26, a review of R4's clinical record was reviewed and revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: coronary heart disease, paranoid schizophrenia, type II diabetes and psychotic disorder. A review of R4's Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14/15. R4's care plan noted: Focus: (R4) has pressure ulcer(s) on coccyx R/T (related too) immobility.Interventions: APM Mattress (Alternating Pressure Mattress) . (dated 11/25/25). Hospital Records (11/26/25-12/3/25): . Admitting diagnosis: Sepsis.Hospital Problems: Principal Sepsis.Pressure Injury of coccygeal region, stage 3.Wound Care Instructions.Specialty mattress: Low air-loss.Turn patient q (every) 2 hours with a wedge.avoid adult briefs to limit moisture to skin. Hospital Records (12/30/25-1/9/26): .Surgical Wound Care Consult.the patient was last seen by our service on 12/1/2025 for stage III pressure injuries of the coccyx and right buttock.Review of Systems: Constitution:.Positive for pain.Skin: positive for wounds.Focal examination of wounds.Location: Sacrum: stage 3 pressure injury.Right buttock: stage 3 pressure injury.Location: stage 3 pressure injury.Plan.Turn q 2hours with placing pillow between knees and ankles.Specialty Mattress (air loss). On 1/13/26 at approximately 10:40 AM, R4 was observed lying in bed on their back. They did not have a low air loss mattress. There was no wedge observed in R4's room/bed. R4 was asked if they had a wound and if they were receiving treatment. R4 noted that there was one on their bottom and it hurt. They also noted wounds on their heels. When asked if they were receiving care and the status of their mattress, R4 was not aware of the type of mattress they had. R4 reported that they remember going to the hospital regarding their wound. When asked about their treatment, they noted that they turn them enough. On 1/14/26 at approximately 10:40 AM, Nurse EE was asked why R4 did not have a low-air-loss mattress as their medical record noted they should. Nurse EE confirmed that they did not have the low-air-loss mattress and stated they spoke with the wound nurse, and they stated the wound was a stage II and they did not need it. On 1/14/26 at approximately 11:55 AM, an interview and record review was conducted with Wound Nurse N. Wound Nurse N was queried as to why R4 did not have a low-air-loss mattress and the wound stage diagnosis. Nurse N reported that low-air-loss mattresses are generally used for residents with stage 3 or above. When asked if they reviewed the hospital records and/or care plan that indicated R4 had a stage 3 and needed a low-air-loss mattress, Nurse N reported that they did not review the discharge hospital notes (1/9/26).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2711600. Based on observation, interview, and record review, the facility failed to ensure interventions were implemented to prevent falls for one (R85) of five residents reviewed for accidents, resulting in additional falls from bed. Findings include: On 1/12/26 at 10:20 AM, R85 was observed lying in bed on a regular mattress. R85 did not speak English and was unable to answer questions. A review of R85's clinical record revealed R85 was admitted into the facility on [DATE] with diagnoses that included: dementia, osteoporosis, and essential hypertension. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R85 had moderately impaired cognition, required substantial/maximal assistance to go from lying to sitting on the side of the bed and when transferred from the chair to the bed or the bed to the chair. The assessment noted R85 was always incontinent of urine and stool and did not have any falls since admission into the facility. A review of R85's progress notes revealed the following: A Nursing - Progress Note dated 12/24/25 that noted, Resident with decline in ADL (Activities of Daily Living) function. Needs assistance with dressing, ambulating and toileting 1-2 person assist. Resident not a 1:1 feed. Physician made aware of change in condition . Notes written on 1/11/26 at 6:31 PM and 1/12/26 at 9:30 PM indicated R85 fell on two occasions. A review of R85's care plans revealed a falls care plan initiated on 12/4/25 that noted, At risk for falls secondary to decreased mobility, requires assist with adls, cognition, incontinent of bowel/bladder, medication side effects. Documented interventions included, Bolsters to bed to define mattress edge initiated on 1/13/26 and non-skid mat to right side of bed initiated on 1/11/26. A review of R85's incident reports revealed the following: An incident report for an Un-Witnessed Fall on 1/11/26 at 5:00 PM documented, Writer called to room by staff and observed res (resident) face down on side of bed on the floor .Resident unable to give description .Oriented to Person (only) .Notes: 1/13/2026 IDT (Interdisciplinary Team) met to review residents fall without injury 1/11/26. Nursing intervention to initiate neuro checks and frequent staff rounding IDT additional recommendation to add over lay barrier to mattress, nursing to communicate mattress need with maintenance and follow up when placed . An incident report for an Un-Witnessed Fall on 1/12/26 at 9:30 PM documented, Writer entering residents room observed resident on right side lying on floor near bed and nightstand .Resident Unable to give description .Educated resident on using call light and waiting for assistance. Placed call light within reach .Notes .1/13/2026 IDT met to review residents fall without injury 1/12/26. Nursing intervention to educate resident on the importance of using call light and waiting for staff assistance. MD (medical doctor) agreed with intervention. On 1/14/26 at 10:00 AM, R85 was observed lying in bed sleeping on a regular mattress. There were no bolsters or mattress overlay observed on the bed. A mattress overlay was observed in R85's wheelchair. No non-skid floor mat was observed to the right side of the bed. On 1/14/26 at 10:03 AM, an interview was conducted with Licensed Practical Nurse (LPN) 'P', the nurse assigned to R85. When queried about why the mattress overlay was not applied to R85's bed, LPN 'P' stated, What is that? LPN 'P' observed R85's room and said the mattress overlay must be what was in the wheelchair and said she did not know anything about it. When queried about whether she knew R85 had two falls from bed on 1/11/26 and 1/12/25, LPN 'P' looked in a binder on the medication cart and said R85 had neuro checks in place. On 1/14/26 at 10:12 AM, an interview was conducted with Unit Manager, Registered Nurse (RN) 'B'. When queried about why the mattress overlay was not applied to R85's bed, RN 'B' said it was. When queried about why the non-skid floor mat was not to the right side of the bed, RN 'B' said We don't use floor mats at this facility. At that time, an observation of R85's room was conducted with RN 'B'. RN 'B' acknowledged (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the mattress overlay was not applied to the bed and was placed in the wheelchair. On 1/14/26 at 10:30 AM, an interview was conducted with the Director of Nursing (DON). The above observations of the mattress overlay and non-skid mat not being in place for R85's per the care plan and IDT recommendations were discussed. The DON stated, They would not document it until it was in place. It was reiterated that the interventions were not in place and was confirmed by RN 'B'. The DON did not offer a response.

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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 2711600Based on observation, interview and record review the facility failed to ensure accurate weights were obtained and accurate assessments were completed for one (R64) of six residents reviewed for nutrition resulting in R64's actual weight being 29.6 pounds [Lbs] less than the documented weight indicating severe weight loss. Findings include:On 1/12/26 at 10:45 AM, R64 was observed lying in bed. R64 appeared very thin, and as R64 was not wearing a shirt or slacks, he was only clothed in a brief, the definition of ribs was noticeable along with thin arms and legs. Review of the clinical record revealed R64 was admitted into the facility on 3/22/24 and readmitted on [DATE] with diagnoses that included: quadriplegia, major depressive disorder and anxiety disorder. According to the Minimum Data Set [MDS] assessment dated [DATE], R64 was cognitively intact and was dependent on staff for all activities of daily living [ADL's].Review of R64's weights revealed monthly weights including:7/7/25 at 2:10 PM weight 149.0 Lbs (pounds) by Hoyer [mechanical lift]9/1/25 at 2:59 PM weight 149.0 Lbs by Hoyer10/17/25 at 4:24 PM weight 148.0 Lbs by Hoyer11/10/25 at 12:01 PM weight 149.0 Lbs by Hoyer12/3/25 at 2:14 PM weight 148.6 Lbs by Hoyer12/12/25 at 2:04 PM weight 121.6 Lbs by Hoyer was crossed out and Incorrect Documentation was given as the reason for the strike out1/9/26 at 2:55 PM weight 149.6 Lbs by HoyerOn 1/13/26 at 10:59 PM, R64 was observed lying in bed. R64 was asked if he was weighed by the staff. R64 explained they had weighed him occasionally. R64 was asked what he thought he weighed currently. R64 explained he probably weighed 132 Lbs. When asked how tall he was, R64 explained he was 6 foot 1 inches tall.On 1/14/26 at 1:37 PM, observation of Certified Nursing Assistant [CNA] ‘K' and Registered Nurse [RN] ‘B' weighing R64 with a mechanical lift revealed R64's weight as 120.0 Lbs. It should be noted that the documented weight of 149.6 on 1/9/26 was 29.6 Lbs more than R64's actual weight indicating a 19.79% weight loss in five days.On 1/14/26 at 1:53 PM, Registered Dietician [RD] ‘M' was interviewed and asked about R64's weights. RD ‘M' explained she was currently working on R64's Nutrition Evaluation, and his weights' had not flagged any concern as his weights had appeared to be stable. When informed of the observed weight of 120.0 Lbs, RD ‘M' explained she would go and see R64. On 1/14/26 at 2:15 PM, Licensed Practical Nurse [LPN] ‘L', who had crossed out the 121.6 Lbs weight on 12/12/25, was called and a voicemail was left. No return call was made prior to the end of the survey.On 1/14/26 at 2:25 PM, the Director of Nursing [DON] was interviewed and asked how the accuracy of resident weights was monitored. The DON explained the CNA's weighed the residents and the weight was entered into the chart. The DON was asked how was it possible to have a 29.6 Lbs weight discrepancy between R64's weight in the chart as 149.6 on 1/9/26 and the observed weight on 1/14/26 of 120.0. The DON explained he would look into it and come back with information. No further information was provided prior to the end of the survey.On 1/14/26 at 2:30 PM, RD ‘M' explained she had observed R64 and agreed R64 did not look like he would weigh 149.6 Lbs.On 1/14/26 at 2:36 PM, an email was sent to the facility requesting a policy on Weight Management including obtaining accurate weights. No policy was provided prior to the end of the survey.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. This citation pertains to Intakes 2711600 and 2703853. Based on interview and record review, the facility failed to ensure sufficient nursing staff on the 2 [NAME] Unit for three (R4, R9, R11) residents reviewed, resulting in resident's not receiving their medications according to physician's orders. This had the potential to affect all residents who resided on the 2 [NAME] Unit. Findings include:A review of a complaint submitted to the State Agency revealed an allegation that on 12/25/25, the facility was short staffed from 7:00 PM until 11:00 PM on the 2 [NAME] Unit. The complaint alleged there was no nurse during those times and therefore the residents did not get their medications timely. The complaint noted staff said they were going to send help, but they did not send anyone until 11:20 PM. On 1/14/26 at approximately 4:00 PM, an interview was conducted with Staffing Coordinator (SC) 'E'. When queried about any staffing challenges on second shift on 12/25/25, SC 'E' reported two night nurses called in. When queried about what was done to fill those spots, SC 'E' reported she was not the person on call that day, but she thought nurse managers came in. SC 'E' said Unit Manager, Licensed Practical Nurse (LPN) 'L' came in, but she was not required to punch in because she was a manager and was salary. On 1/14/26 at approximately 5:00 PM, an interview was conducted with the Administrator and SC 'E'. A request for the names of the nurses who were assigned to the 2 [NAME] Unit on 12/25/25 between 7:00 AM and 11:00 PM were requested. Evidence that those nurses actually worked was also requested. At that time, the Administrator reviewed the time punches along with SC 'E' and they reported there were two nurses assigned to the 2 East Unit, one nurse for 1 West, and one nurse for 1 East. They said they were still trying to get the assignment sheet for 2 [NAME] and would follow up. On 1/14/26 at 5:31 PM, the assignment sheet for the 2 [NAME] and 2 East Units on 12/25/25 was provided by the facility. The assignment sheet was reviewed at that time and revealed the following: Unit Manager, Licensed Practical Nurse (LPN) 'L' was assigned to the 2 [NAME] Unit from 7:00 PM until 11:00 PM along with LPN 'U'. Unit Manager, Registered Nurse (RN) 'V' was assigned to the 2 [NAME] Unit from 11:00 PM until 7:00 AM along with RN 'Q'. RN 'Q' was also documented as assigned to the 2 East Unit during the same time frame. A review of time punches of all nursing staff who worked on 12/25/25 was reviewed and the following was revealed: LPN 'U' punched in at 7:00 AM and punched out at 8:59 PM. However, they were listed as a nurse assigned from 7:00 PM until 11:00 PM on the 2 [NAME] unit. LPN 'L' did not have a time punch due to being salary and not required to punch in. RN 'V' punched in at 11:15 PM and punched out at 8:15 AM. RN 'Q' punched in at 7:00 AM and punched out at 11:45 PM. No missed punches were provided by the facility with the time punches. A review of residents who resided on the 2 [NAME] Unit on 12/25/25 was conducted. A review of R4's Medication Administration Record (MAR) for December 2025 revealed they had orders for the following medications scheduled for administration at 9:00 PM on 12/25/25: Atorvastatin 80 milligrams (MG) at bedtime (9:00 PM)Colace 100 MG every 12 hours for constipation (9:00 AM and 9:00 PM)Eliquis (a medication used to prevent blood clots) 5 MG every 12 hours (9:00 AM and 9:00 PM)Metoprolol Tartrate (a medication used to treat high blood pressure) 25 MG two times a day (9:00 AM and 9:00 PM)Tizanidine HCl (a medication to treat muscle spasms) 4 MG three times a day (9:00 AM, 1:00 PM, 9:00 PM) All of the above medications were signed off as given by RN 'V' who did not punch in for their shift until 11:15 PM. Over two hours after the medications were due. A review of R9's Medication Administration Record (MAR) for December 2025 revealed they had orders for the following medications scheduled for administration at 9:00 PM on 12/25/25: Divalproex Sodium (a medication used to treat bipolar disorder and/or seizure disorder) 125 MG two times a day (9:00 AM and 9:00 PM)Voltaren External Gel (a topical medication used to treat pain from arthritis) in the morning and at bedtime (9:00 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AM and 9:00 PM) All of the above medications were signed off as given by RN 'V' who did not punch in for their shift until 11:15 PM. Over two hours after the medications were due. A review of R11's Medication Administration Record (MAR) for December 2025 revealed they had orders for the following medications scheduled for administration at 9:00 PM on 12/25/25: Atorvastatin Calcium 40 MG at bedtime (9:00 PM)Lantus (insulin) Inject 12 units at bedtime (9:00 PM)Gabapentin (medication used to treat nerve pain) 300 MG four times a day (9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM) All of the above medications were signed off as given by RN 'V' who did not punch in for their shift until 11:15 PM. Over two hours after the medications were due. On 1/14/26 at approximately 5:45 PM, an interview was conducted with the Director of Nursing (DON) in the presence of Assistant Director of Nursing (ADON) 'W'. When queried about whether they were aware of any staffing challenges on 12/25/25, the DON reported he was not aware. The ADON reported the nurse managers came in. At that time, evidence of when they came and left was requested. The DON was further interviewed about how RN 'V' signed out medications due at 9:00 PM but did not punch in until 11:15 PM and acknowledged the concern and said he would look into it. On 1/14/26 at approximately 6:00 PM, the DON followed up with RN 'V'. RN 'V' reported she came in early but didn't punch in until 11:15 PM. RN 'V' reported she did not request a missed punch from Human Resources because she was also a manager. At that time RN 'V' was asked if she could provide evidence of when she arrived and left on 12/25/25 and she said she could not. The DON asked what he could provide to show evidence of the hours worked by RN 'V'. At that time the audit report of medication administration times was requested for the resident's medications above. The DON reported corporate staff said they were unable to access that report. No further information was provided prior to the end of the survey.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate less than five percent when two medication errors out of 27 opportunities for error were observed for two (R110 and R70) of three residents reviewed during the medication administration observation, resulting in a 7.41% error rate. Findings include:On 1/13/26 at 8:16 AM, Licensed Practical Nurse [LPN] ‘I' was observed as part of the medication administration task. LPN ‘I' prepared seven medications for R110, including one Senna Plus [a combination constipation medication including senna and docusate] 8.6-50 mg [milligrams]. LPN ‘I' was observed to enter R110's room and administer all seven medications to R110.On 1/13/26 at 8:31 AM, LPN ‘H' was observed preparing eleven medications for R70, including one Geri-Kot [a senna laxative] 8.6 mg (milligrams). LPN ‘H' was observed to enter R70's room and administer all eleven medications to R70.On 1/13/26 at 3:30 PM, R70's physician orders were compared to the medications observed to have been given by LPN ‘H'. The reconciliation revealed R70 had an order for Sennosides-Docusate Sodium 8.6-50 mg. On 1/13/26 at 3:43 PM, R110's physician orders were compared to the medications observed to have been given by LPN ‘I'. The reconciliation revealed R110 had an order for Senna 8.6 mg.On 1/14/26 at 8:40 AM, the Director of Nursing [DON] was interviewed and asked if Senna Plus could be given if the physician order was for Senna. The DON explained no, Senna Plus also included Docusate and could not be given unless ordered. The DON was asked if Geri-Kot could be given if the physician order was for Sennosides-Docusate. The DON explained no, as Geri-Kot did not include Docusate.Review of a facility policy titled, Medication Administration dated 8/7/23 read in part, .To safely and accurately prepare and administer medication according to physician order. Medications are administered I accordance with the following rights of medication administration: Right resident, Right medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews the facility failed to maintain an ongoing Infection Control Surveillance system and ensure the consistent implementation of the facility's policies and procedures for the Infection Prevention and Control program. This deficient practice had the potential to affect all residents that resided in the facility, including R's 65, 57, 121, 48, 70, 113, 64, 106, 74, 5, 4, 99, and 62 of 13 residents reviewed for Infection Control. Findings include:On 1/12/26 at 9:48 AM, a signage for contact precautions was observed on the door of R65. It alerted staff and providers to don on gown and gloves upon entering the room. An observation of the Personal Protective Equipment (PPE) cart next to R65's door was conducted and revealed no gloves inside the cart for staff and providers to utilize. Another PPE cart across the hall was observed and again contained no hand gloves for staff and providers to utilize. At 9:51 AM, Unit Manager (UM) HH was asked to look into the PPE carts located outside the contact and enhanced barrier precaution rooms on the first floor. UM HH confirmed there were no gloves located in the carts for staff and providers. UM HH directed an aide to obtain boxes of gloves for the carts. On 1/12/26 at 9:59 AM, an interview with R57 conducted inside their room had started when UM HH was observed to have placed a signage on the resident's door. At that time the interview with R57 was paused and UM HH was asked what signage they were putting up. UM HH stated they were placing an enhanced barrier precaution sign. UM HH was asked why they had not had the signage up prior to the surveyor entering into the room and UM HH did not have a response. After completion of the interview, UM HH was observed at the nurses station at 10:38 AM. UM HH stated they were not sure what happened and stated R57 was readmitted from the hospital over the weekend and they were now ensuring all of their orders were put into the system correctly. When asked whose responsibility it was to ensure that this was done upon readmission, UM HH stated the nurses. INFECTION SURVEILLANCE PROGRAM A review of a facility policy titled Covid-19 revised 10/26/23, documented in part . Policy Overview: To establish a facility-wide system for the prevention, identification, reporting, investigation, and control practices designed to minimize transmission of Covid-19. Such as proper use of personal protective equipment (PPE), transmission precautions which reflect current standards of practice, and/or other relevant infection prevention and control practices are in place. Testing Trigger. Symptomatic individual identified. Residents, regardless of vaccination status, with signs and symptoms must be tested. A review of the Centers for Disease Control and Prevention (CDC) titled . Testing for SARS-CoV-2 for Health Care Providers, dated 8/29/24, documented in part . Testing individuals with signs or symptoms consistent with COVID-19. Additionally, consider other illnesses with similar symptoms that may require testing. For many diseases, including flu, early diagnosis and prompt treatment can be important for preventing severe illness. Overview of Testing for SARS-CoV-2 | COVID-19 | CDC A review of the CDC guidance titled Infection Control Guidance: SARS-CoV-2 dated 6/24/24, documented in part . This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes. The recommendation in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency. Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection. Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: -A positive viral test for SARS-CoV-2, -Symptoms of COVID-19 or Close contact with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	someone with SARS-CoV-2 infection. Infection Control Guidance: SARS-CoV-2 | Covid | CDC A review of the CDC guidance titled Symptoms of COVID-19, dated 3/10/25, documented in part . Possible symptoms include: Fever or chills, Cough, Shortness of breath or difficulty breathing, Sore throat, Congestion or runny nose, New loss of taste or smell, Fatigue, Muscle or body aches, Headache, Nausea or vomiting, Diarrhea. Symptoms of COVID-19 | COVID-19 | CDC A review of the Infection Surveillance Program revealed the following: R106- Review of an Infection Report Form onset date 12/30/25, documented cough and congestion. A Nurse Practitioner (NP) progress note dated 12/30/25 at 8:10 AM, documented in part . slightly wheezing left anterior and posterior lung. R74- Review of an Infection Report Form onset 12/30/25, documented in part . cough. A NP progress note dated 1/6/26 at 8:00 AM, documented in part . occasional productive cough. continues to have congestion and stuffy nose, occasionally patient reports of headache. R5- Review of Social Services note dated 11/28/25 at 10:36 AM, documented in part . feeling ill. A Nursing note dated 11/28/25 at 12:45 PM, documented in part . Fever. 101.5. R4- Review of an Infection Report Form onset 11/26/25, documented in part . elevated labs, leukocytosis (high white blood cell count), SOB (shortness of breath), cough, temp (temperature). A Medical Doctor (MD) note dated 11/25/25 at 12:12 PM, documented in part . reports nausea and vomiting which began yesterday. reports looser stools. She has an associated persistent cough and us unable to participate in therapy due to feeling unwell. R99- Review of an Infection Report Form onset 12/10/25, documented in part . lethargic, cough. A Nursing note dated 12/10/25 at 11:43 PM, documented in part . Resident is hard to arouse. A MD (Medical Doctor) note dated 12/11/25 at 11:10 AM, documented in part . has a cough. arousable but has difficulty with arousal. Review of the medical records for R's 106, 74, 5, 4, and 99 revealed no documentation of the residents to have been tested per the facility policy and CDC guidance. On 1/14/26 at approximately 9:04 AM, the Infection Control Preventionist (ICP) W was interviewed and asked the facility protocol and practices for testing residents who are symptomatic for respiratory infections and/or COVID-19. ICP W stated they would notify the doctor and follow the physicians orders. ICP W was asked if they adhered to the Centers for Disease Control and Prevention guidance for testing of symptomatic residents for COVID-19 and their facility policy regarding COVID-19 and Influenza testing of symptomatic and ICP W responded they follow CDC guidance and their policy for the surveillance of the facility's infections. ICP W was then asked why R's 106, 74, 5, 4 and 99 were not tested for COVID-19 despite documentation from their surveillance program and the residents medical records to have contained documentation revealing that all were symptomatic and ICP W stated they (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were unsure on why these residents were not tested and would have to follow up and get back to the surveyor. At 12:44 PM, ICP W returned and stated residents who are symptomatic are now being tested moving forward. No further explanation or documentation was provided by the end of the survey. On 1/12/26 at 10:34 AM, a Contact Precautions sign was taped on R121's door. Licensed Practical Nurse [LPN] 'AA' was asked why R121 was in Contact Precautions. LPN 'AA' explained R121 had wounds and anyone with wounds was put on Contact Precautions. Observation of the isolation cart in the hall outside R121's room revealed no gloves in the cart. Review of the clinical record revealed R121 was in Contact Precautions for CRE [Carbapenem-resistant Enterobacterales] in the urine. On 1/12/26 at 11:45 AM, a Contact Precaution sign was observed on R48's door. R48 was observed lying in bed. R48 was asked if staff was wearing isolation gown and gloves when they were in the room. R48 explained they were not. After removing gown and gloves to exit the room, no garbage can could be found in R48's room or bathroom. On 1/13/26 at 8:42 AM, LPN 'H' was observed as part of the medication administration task. One of R70's medications was not in the medication cart. LPN 'H' walked to a different Unit, used a computer at the nurse station, retrieved the medication from the backup, walked back to R70's room, placed the medication in a medication cup and gave it to R70 with no hand hygiene performed. On 1/13/26 at 9:10 AM, LPN 'G' was observed as part of the medication administration task. As R113 was tipping the medicine cup filled with seven pills to her mouth, one pill fell out and landed on her lap. LPN 'G' grabbed the pill with her ungloved hand and placed it back into the medication cup and R113 then took the pill. One medication was not in the cart, LPN 'G' went to the nurse station and obtained a stock bottle of medication, returned to the medication cart, removed the safety top on the bottle, then shook one pill into the palm of her ungloved hand and put the pill in a medicine cup and gave it to R113. On 1/13/26 at 10:44 AM, observation of R64's wound care with LPN 'N', who served at the Wound Treatment Nurse, revealed LPN 'N' flicking her unrestrained long hair that was falling in front of her face then continuing treatment on R64's wounds with the same gloves. On 1/13/26 at 11:12 AM, observation of R121's wound care with LPN 'N' revealed no gloves in the isolation cart outside of R121's room. LPN 'N' was asked about the gloves. LPN 'N' explained since R121 was in Contact Precautions, the gloves were inside the room. Observation of the Contact Precaution sign read gloves were required before entering the room. LPN 'N' prepared the supplies needed for the wound treatment, placed them on foam trays and took the trays into the room and placed the supplies on a dresser inside of the room without wearing any PPE. LPN 'N' then exited the room and put on a gown and mask, entered the room and put on gloves and moved the supplies to a tray table. While performing wound care, LPN 'N' needed more supplies, she walked to the doorway, removed her gown and gloves, then without performing hand hygiene opened the treatment cart and removed additional supplies. On 1/14/26 at 8:40 AM, the Director of Nursing [DON] was asked if nurses were allowed to touch pills with their bare hands. The DON explained pills should not be touched with bare hands. The DON was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	asked when hand hygiene should be done. The DON explained if hands were visibly dirty, they should be washed with soap and water, but there was alcohol based cleanser stationed all over the facility and on the medication carts to clean hands. The DON was asked if gloves should be kept in an isolation cart, or inside a Contact Precaution room. The DON explained gloves should be in the isolation cart. On 1/12/26 at 10:06 AM, during an observation of the 2 East Unit, a bin that contained Personal Protective Equipment (PPE) was observed to have a heavily soiled mask with dried brown and orange stains stored inside the top drawer with the clean masks. A second PPE bin located on the same hallway was observed to have dried brown substance all over the outside of the bin. In order to open the drawers, the dried brown substance would have to be touched. On 1/12/26 at 10:29 AM, R62's door was observed with no signage that indicated the resident was on any type of preventative or isolation precautions. At that time, during an interview with R62, Certified Nursing Assistants (CNA) 'D' and 'C' entered R62's room with a mechanical lift and began to provide care to the resident. Upon exiting R62's room there was a sign hung on the door (that was not there prior to entering) that indicated R62 was on Enhanced Barrier Precautions (EBP - a protective measure to prevent transmission of multi-drug resistant organisms) and all staff that provided care were required to don a gown, gloves, and mask prior to entrance into the room. On 1/12/26 at 10:48 AM, CNA 'C' exited R62's room and an interview was conducted. When queried about why they did not don PPE prior to entering R62's room and providing care as the sign indicated, CNA 'C' reported they worked for a staffing agency, it was their first day back, and that the sign was not hung on the door prior to them entering the room. On 1/12/26 at 10:50 AM, CNA 'X' opened the drawer of the PPE bin that contained the soiled mask and closed the drawer without removing the mask or disposing of the clean masks stored with the dirty ones. On 1/12/26 at 11:16 AM, CNA 'D' opened the top drawer of the PPE bin that contained the soiled mask and closed the drawer without removing the mask or disposing of the clean masks stored with the dirty ones. At that time, Licensed Practical Nurse (LPN) 'Y' opened the drawer and removed the soiled mask and threw it out in the medication cart trash compartment and closed the drawer. At that time, Central Supply Staff (CS) 'Z' was on the unit stocking the PPE bins with equipment. LPN 'Y' was interviewed about the soiled mask and she acknowledged it was not supposed to be in there. At that time CS 'Z' said all the clean masks had to be disposed off and the bin had to be sanitized. At that time, the other bin with the dried brown substance on it was pointed out to CS 'Z' who said it would need to be sanitized and stated, It has an odor. On 1/14/26 at 8:44 AM, an interview was conducted with the Director of Nursing (DON). The above observations were shared with the DON. The DON reported he understood the concerns.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain an effective antibiotic stewardship program to monitor the appropriateness of antibiotic use for two (R's 3 and 104) of two residents reviewed for the antibiotic stewardship. Findings include:R3A review of the medical record revealed R3 was initially admitted to the facility on [DATE], with a readmission date of 12/18/25 and diagnoses that included: anxiety disorder, bipolar disorder, and adjustment disorder.A review of an Infection Report Form Onset Date: 12/16. documented in part . mental status change, lethargic, fever. Cephalexin 500mg (milligrams)/3xday/oral. Total Days of Therapy: 10.A review of the McGeer Criteria Worksheet attached to the Infection Report Form was blank.A review of the medical record for R3, revealed no documentation of the identified mental status change, lethargic, fever.A review of a Nursing note dated 12/16/25 at 2:23 AM, documented in part . Pt (patient) requested to see the nurse. pt requested to see the nurse. pt stated that she could see mold on the floors and having a hard time breathing. Writer raised HOB (head of bed), auscultated lung sounds and assessed vital signs. No abnormalities noted, pt disagreed. Writer examined the room for hazardous conditions, none found. Writer offered for floors to be swept and mopped, pt declined, asking to speak with a supervisor on duty. After writer notified the supervisor on site, Pt made the decision to contact EMS (emergency medical services) to transport her . to the hospital.Further review of the record revealed multiple documentation of episodes of disruptive behaviors, yelling, refusals of care, irritability, agitation and frustration, which appeared to be the resident's baseline.A Nursing note dated 12/18/25 at 5:22 PM, documented in part . resident had called 911 to come take her to the hospital due to canker sores in her mouth.A nursing note dated 12/18/25 at 11:47 PM, noted the resident arrived back at the facility.A nursing note dated 12/19/25 at 1:28 PM, documented in part . found foaming at the mouth, cyanotic, shaky, and unresponsive. 911 called. Pt regained conscious, and was alert. with confusion. pt transferred back to the hospital.A nursing note dated 12/19/25 at 6:10 PM, documented in part, . Pt arrived from (hospital name). New orders received; Cephalexin 500mg tid (three times a day) for 10 days for a mild UTI (urinary tract infection).A review of the medical record revealed no documentation of the reviewal of the appropriateness of the antibiotic or labs or culture reports from the hospital. R104A review of the medical record revealed R104 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included: paranoid schizophrenia, psychotic disorder with hallucinations and adjustment disorder.A review of an Infection Report Form Onset Date 12/11/25, documented in part . Signs and Symptoms (blank). Augmentin 500-125mg/Q12h (every 12 hours)/oral. Date 12/11/25. Treatment #1 Augmentin 500-125mg/Q12h/oral. Start Date: 12/24/25. Stop Date 12/31/23. Treatment #2 Augmentin 500-125 mg/Q12h/oral. Start Date 12/15/25. Stop Date: 12/16/25.Review of a blank McGeer Criteria Worksheet was attached to the Infection Report Form. A urinalysis and culture report was attached to the Infection Report Form that noted Escherichia coli, > (more than) 100,000 found in the resident urine and reported to the facility on [DATE].A review of a NP note dated 12/11/25 at 9:00 AM, documented in part . Following after report from staff that patient was physically aggressive to facility staff. Patient in bed, she is somewhat irate, does not want to be bothered, she states she wants to go home. She has no complaints, no respiratory distress and discomfort no pain. A recent verbal and physical aggression with nursing staff. CBC (complete blood count), CMP (comprehensive metabolic profile), UA (urinalysis), CS (culture report), psych eval (evaluation). Vascular dementia, moderate with behavioral disturbance. Psychiatric illness/MDD (major depressive disorder) with history of suicidal ideation.Further review of the record revealed prior incidents of use of inappropriate language towards staff, attempting to hit staff, refusals of (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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications/care, frustration, irritability, and verbal aggression.A review of the December 2025 Medication Administration Record (MAR) revealed the following:Start Date 12/15/25 Augmentin 500-125 mg every 12 hours for a UTI, for seven days. This order stopped on 12/16/25, with a total of one dose administered.Start Date 12/23/25 Augmentin 500-125 mg every 12 hour or a UTI, this order stopped on 12/24/25 with a total of two doses administered.Start Date 12/24/25 Augmentin 500-125 mg every 12 hours for UTI for 7 days. This order stopped on 12/31/25, completing the full regime ordered.Review of the medical record revealed no documentation of the appropriateness of the antibiotic or documentation of the resident to have met the criteria of an infection.On 1/14/26 at approximately 9:07 AM, the Infection Control Preventionist (ICP) W was interviewed and asked how they review and ensure the appropriateness of the antibiotics prescribed to the facility residents and ICP W explained they run a report every morning to see who is on antibiotics. ICP W stated they would get in touch with the doctor and go over the antibiotics. ICP W was asked where they document their conversation with the Physician regarding reviewing the appropriateness of the antibiotics and ICP W stated they . just realized that it should be documented in the record. ICP W was asked to provide all documentation they had regarding the reviewal of appropriateness for R's 3 and 104 antibiotics for review. ICP W stated they would look into it and follow back up.No further explanation or documentation was provided by the end of the survey.