STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235226	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Blanc	11941 Belsay Road Grand Blanc, MI 48439

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** Based on interview and record review, the facility failed to implement care plan interventions for one resident (Resident #3) of three residents reviewed for falls, resulting in a fall with fracture. Findings include:Resident #3 (R3): R3 most recently admitted to the facility on [DATE] with diagnoses that include a right femur fracture, a left femur fracture, muscle wasting and repeated falls. On 02/22/2026 at 1:07PM, during an interview, R3 was asked if he had sustained any falls while in the facility. R3 stated that in September he fell out of bed while receiving a bed bath. R3 stated that one staff member left the room while another staff member performed the bed bath. R3 stated the staff member had rolled him in the bed and was behind him drying his back. R3 said he told the staff member performing the bed bath that he was sliding off the bed and they didn't help me and then I hit the floor. R3 stated that he broke both of his legs, chipped his tooth and was hospitalized . R3 was asked if either of the staff members from that day still work in the facility. R3 stated, one of them still works here and the other one was fired as far as i know. On 02/24/2026 at 12:02PM, record review of an incident report from 9/24/25 revealed that R3 fell out of bed during care and sustained multiple injuries. R3 was sent to the emergency room for evaluation and treatment of his injuries. X-rays showed a comminuted impacted supracondylar/intercondylar fracture of left femur and impacted supracondylar fracture of the right femur. R3 stated he rolled out of the bed as the aide was trying to dry his back. On 2/24/2026 at 12:12PM, record review of care plans for R3 revealed he is a two-person total assist for bed mobility currently and was a two-person total assist at the time of the fall for bed mobility. At the time of the fall R3 was a one-person total assist for bathing, the care plan has been updated to a two-person total assist. The activities of daily living (ADL) definition of bathing refers to the ability to wash oneself in the bathtub or shower. On 02/24/2026 at 12:22PM, an interview was conducted with the Director of Nursing (DON). The DON was asked why the fall for R3 was not reported. The DON stated there was no deficient practice we could identify, we were following the care plan and there was no indication of abuse. We suspended the CNA pending investigation and did a thorough investigation. On 02/24/2026 at 1:41PM, an interview was conducted with Certified Nursing Assistant (CNA) K. CNA K was asked to describe what happened that lead to R3 falling out of bed. CNA K stated we (another CNA was present at the time) were about to give R3 a bed bath and I had to grab an extra person to help me. R3 and the other employee got into it, the other aide said well I'm not your aide I am just helping, and she left. CNA K stated, I gave him a bed bath alone, he was agitated and rushing me to get him up and ready by 11:45am. CNA K was asked if it is a common practice to roll residents away from you when providing care. CNA K stated, yes, we do it all the time, we roll them away and they grab the rail. CNA K was asked if there should have been a second staff member with them to perform the bed bath. CNA K stated, yes, I should've had another person with me. Review of the policy titled, Falls, Clinical Protocol, revealed: 5. Interventions should be developed and implemented per the assessed needs. Additional items to remember when developing the plan of care include;-Resident's abilities and deficits-Balance (sitting/standing)-Adaptive equipment needs-Proper use of mechanical lifts and transfer devices, (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	shower beds, shower chairs, bathroom safety On 02/24/2026 at 1:52PM, during the onsite survey, Past Non-Compliance (PNC) was cited after the facility implemented actions to correct the non-compliance which included: 1. The facility implemented interventions for the resident involved.2. All facility residents are at risk for improper ADL care. An audit was completed by the unit manager to ensure Kardex and Care Plans are accurate, consistent and appropriate to meet the resident's needs. Any issues were addressed upon discovery. 3. Education was provided to the nursing staff on following the Kardex to perform ADL care and notifying the nurse manager if there are any discrepancies/inconsistencies in how to provide care. ADHOC was completed on 9/25/25.4. Audits are being completed to ensure compliance.5. Date of compliance: 9/25/2025.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area, resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings include: On 02/23/2026 at 8:55am during the kitchen tour with Certified Dietary Manager D and Regional Dietician E, observed a loose cap to the atmospheric vacuum breaker on the water line to the dishwasher. During this observation, CDM D was interviewed on the broken backflow preventer, and she stated that a contractor came out to repair it a couple weeks ago because it was spewing out water. According to the FDA 2022 Food Code, 5-205.15 System Maintained in Good Repair, A plumbing system shall be: repaired according to law.and maintained in good repair. On 02/23/2026 at 9:01am observed the drain line to the ice machine sitting directly inside a drain. According to the 2022 Food Code, 5-202.13 Backflow Prevention, Air Gap, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). On 02/23/2026 at 9:05am observed two pans covered with aluminum foil sitting on the counter. During this observation, CDM D was asked what was in the pans and she stated she wasn't sure. CDM D uncovered the pans to find gravy stored inside the pans. Both pans of gravy were temped at 130 degrees F and 135 degrees F using thermometer. When interviewed CDM D on how long the gravy has been sitting on the counter, she stated it's been sitting there since 8am and the gravy is being used for lunch. On 02/23/2026 at approximately 10:50am observed a cooler with the interior lined with a bag with ice stored inside, located in the 100 hallways. On 02/23/2026 at approximately 10:52am observed a cooler with the interior lined with a bag with ice stored inside, located in the 400 hallways. On 02/23/2026 at approximately 11:50am interviewed CDM D on whether the bags lining the interior of the ice coolers are approved for food contact, and she presented the box labeled Sysco Classic Can Liners and stated that these are the bags they've always used for the ice coolers. According to the FDA 2022 Food Code, 4-101.11 Characteristics, Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be .safe .durable, corrosion-resistant, and nonabsorbent. According to the specification sheet of the Sysco Liners provided by the facility, the product is called Liner Trash 38 Inch X 58 Inch 0.95 Mil [NAME] Linear Low-Density Polyethylene with the product described as Sysco Classic linear low-density can liners feature high-quality resin construction for durability, and the star seal on each liner fits neatly inside of waste bins. There is no mention of this product being food contact safe on the specification sheet. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/23/2026 at 11:55am observed [NAME] F handle uncooked breaded chicken while wearing gloves, removed gloves and put on new gloves before proceeding to prepare and temp ready-to-eat food without washing hands. On 02/23/2026 at 12:40pm observed a pan of cooked breaded chicken sitting on top of steam table and it was temped at 101 degrees F with thermometer in the main kitchen. On 02/23/2026 at approximately 12:48pm interviewed CDM D on when should staff wash their hands, and she stated hands should be washed whenever it's needed and before moving onto the next thing. According to the 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms.immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and.Before donning gloves to initiate a task that involves working with food. According to the facility's policy on Dietary Employee Personal Hygiene, Hands must always be washed after using the restroom, eating or drinking, smoking, coughing, sneezing, blowing nose, before putting on gloves and after removing gloves. 02/23/2026 at 12:49pm interviewed CDM D on the pan of breaded chicken sitting on the steam table in the kitchen, and she stated it was left over from the dining room, and she wasn't sure if the intent was to use the leftovers or throw them out. According to the facility's policy on hot holding, Holding - staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed. According to the 2022 FDA Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control . time/temperature control for safety food shall be maintained .at 57 degrees C (135 degrees F) or above. On 02/22/2026 at 10 AM, During an observation before entering the kitchen there was a file outside the kitchen area marked hair nets it contained empty paper holders with no hair nets available. On 02/22/2026 at ~(approximately)10 AM During the initial walk through of the kitchen with certified dietary manager (CDM) D the sink at the main wash station had no soap available and CDM C said there was an order placed for it however it had not come in yet, staff had to use the secondary sink to wash hands, and walked through the kitchen by the dishwashing station to a secondary sink to wash hands. According to the 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation. According to the facility's policy on Dietary Employee Personal Hygiene, Hands must always be washed after using the restroom, eating or drinking, smoking, coughing, sneezing, blowing nose, before putting on gloves and after removing gloves. On 02/22/2026 at ~(approximately)10 AM During the initial walk through of the kitchen an observation (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the back sink was dirty and had used pitcher in it, in the same sink there was a ¾ full prepared large container (used to fill pitchers) labelled lemonade dated 02/21/2026 with expiration of 02/27/2026. CDM C was asked about the unclean sink being used for the storage location and she said it should not be stored like that and would dispose of it. On 02/22/2026 at ~(approximately)10 AM During the initial walk through of the kitchen an observation of the cook prep area revealed a large used food scoop and dirty knife on the counter; the sink was unclean with food particles present. CDM observed and verified staff was not actively present performing food preparation. An observation was made of the clean equipment rack that held 2 sauté pans that had peeled Teflon coating and a vegetable mandolin slicer that had a soiled handle and mold in the grove. The CDM C verbalized verified observation and put them in her office to throw out. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 02/22/2026 at ~(approximately)10 AM During the initial walk through of the kitchen an observation of the refrigerator contained: A tin pan labelled chicken rice soup with an expiration date of 2/20/26; A container of cooked ground beef that was labelled with a discard date of 2/19/26; 4 individual servings of yogurt dated with expiration 2/21/26; A box that contained ham lunchmeat slices with expiration date of 2/18/26. CDM observed and verbally verified expired dates and removed items from the refrigerator to discard. According to the facility's policy on food safety requirements, . food will be stored, prepared, distributed and served in accordance with professional standards for food service safety and defined food service safety as .handling preparing and storing food in ways that prevent foodborne illness. And 3. Iv. Labeling, dating, and monitoring refrigerator food, including, but not limited to leftovers, so it is it is used by its use by date or frozen (if applicable) /discarded . Facility

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, 1) The facility failed to implement and operationalize a comprehensive infection control program, encompassing outcome surveillance, accurate data documentation/analysis resulting in potential infection and the spread of microorganisms and illness to all 126 facility residents, and 2) the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility. Findings include: DPS One: Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program, encompassing outcome surveillance, accurate data documentation/analysis resulting in potential infection and the spread of microorganisms and illness to all 126 facility residents. Findings include: An interview and review of the facility infection control program was completed on 2/25/26 at 1:02 PM with Infection Control Registered Nurse (RN) P and the Director of Nursing (DON). A review of January 2026's infection control data was completed. When queried, RN P revealed they use a mapping tool and a line listing for surveillance. A review and comparison of the mapping tool and the line listing revealed the number of infections included on the line list did not match the number of infections indicated on the mapping tool. When queried regarding the discrepancy, RN P indicated they were not sure. A comparison of the infections was completed with RN P and revealed a Resident with a skin infection was included on the mapping tool but not on the line list for infections. When asked why the skin infection was not included on the line list, RN P revealed the infection was missed. When asked to review their monthly infection control analysis, RN P reviewed the documentation and revealed an analysis had not been completed. The DON then provided a two-page form titled, Monthly Analysis and Summary/QAPI Committee Infection Prevention/Control Report for January 2026. The form included the total infections for the month but did not include any analysis of the infections to identify any potential trends. The total number of infections listed was different from both the number on the line list and the number indicated on the mapping tool. When queried regarding the discrepancy, an explanation was not provided. Further review of the line listing for the month revealed each infection listed received treatment with an antimicrobial medication. When queried regarding potential infections and/or infections which did not require antimicrobial treatment, RN P revealed they did not maintain a line list of infections/potential infections which did not receive treatment. The DON added that the facility had respiratory surveillance documentation due to a Covid outbreak in the facility during January 2026. When asked how infections/potential infections are tracked when there is not an outbreak, both the DON and RN P verbalized the facility did not have a method in place to clearly track potential infections. The line listing had a section titled, Symptom but signs/symptoms of infection for each infection listed were not specified on the documentation. Resident #122 was noted on the line list as having a Healthcare Associated Infection (HAI). The infection site was listed as other. There were no signs/symptoms listed. When queried regarding lack of documentation of signs/symptoms and accurate tracking of infections to prevent spread, both RN (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	P and the DON verbalized understanding. No further explanation was provided. Review of another resident revealed they were treated for a HAI Urinary Tract Infection (UTI). The onset date and the treatment start date for the infection was listed as 1/14/26. The line listing specified a urine sample was obtained on 1/9/26. When queried why a sample was collected on 1/9/26 if the resident's symptoms began on 1/14/26 and if that the actual date the symptoms began, RN P revealed it did not make sense and verbalized they had noticed that previously. Further review of the line listing revealed other residents who were listed as having treatment initiated on the same day as symptoms began. When queried the dates, RN P revealed they would need to review each resident's chart to determine if there were any signs/symptoms of infection documented prior to the date of antimicrobial treatment initiation. When queried regarding the importance of accurate symptom onset date for infection tracking, RN P verbalized understanding. RN P revealed they stepped into the Infection Control Nurse role at the facility within the last few weeks and they had not completed the infection control tracking data for January 2026. With further inquiry, RN P and the DON revealed the prior Infection Control nurse left the position abruptly and both staff verbalized understanding of concerns. Review of Facility policy/procedure entitled, Infection Prevention and Control Program (Reviewed/Revised: 12/27/23) revealed, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases. DPS Two: Based on observation, interview, and record review, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility. Findings include: On 02/24/2026 at 9:01am during the housekeeping tour with Housekeeping Manager G and District Manager H, observed the cap to the atmospheric vacuum breaker missing on the utility sink, located in the janitor's closet in main hallway. On 02/24/2026 at approximately 9:10am observed an uncapped flush valve and an unused atmospheric vacuum breaker, located in the in the soiled utility room in the main hallway. During this observation, Housekeeping Manager G stated there used to be a hopper in the soiled utility room. On 02/24/2026 at approximately 9:15am observed an unused atmospheric vacuum breaker above a flush valve from a removed hopper and below the flush valve is a shut off utility sink, located in the soiled utility room between the 400 and 500 hallways. On 02/24/2026 at 9:21am observed a loose cap to an atmospheric vacuum breaker to the utility sink in the janitor's closet in the rehab dining room. On 02/24/2026 at 9:25am observed an unused hopper with a counter built on top of the basin, located (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in soiled utility room in the 100 hallways. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Eliminate dead legs, which are sections of no- or low-water flow. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. On 02/24/2026 at 10:41am during the environmental tour with Maintenance Director I, when asked whether the hopper is flushed in the soiled utility room in the 100 hallways, he stated he removes the counter over the hopper basin and lets the water run, but they do not have flushing logs. On 02/24/2026 at 10:43am chlorine residual was zero on both hot and cold water taken at the hand sink, using free chlorine strips in room [ROOM NUMBER]. Record review of the facility's monthly assessment log, on 12/18/25 disinfectant residual on hot water was .0 at the utility sink in 100 east and on 9/2/25 disinfectant residual at MSU utility was at .0. The corrective action boxes at the bottom of the logs for 9/2/25 and 12/18/25 are empty. Record review of the facility's water management plan states, When control limits are not maintained, corrective actions will be taken and documented accordingly. and Protocols and corrective actions will reflect current industry guidelines (i.e. ASHRAE, OSHA, CDC). According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Ensure disinfectant residual is detectable throughout the potable water system.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement and operationalize a comprehensive antibiotic stewardship program including analysis and ongoing evaluation of appropriate antibiotic use resulting in the potential development of antibiotic-resistant organisms and inappropriate antibiotic use for all 126 facility residents. Findings include:An interview and review of the facility infection control antibiotic stewardship program was completed on 2/25/26 at 1:02 PM with Infection Control Registered Nurse (RN) P and the Director of Nursing (DON). January 2026's infection control data was reviewed with RN P. When asked what criteria the facility utilizes to assess resident for infection and initiation of antibiotics, RN P stated, McGeer. The line listing documentation did not include if infection/antibiotic use criteria had been met. Additionally, the symptoms section was blank on several of the residents listed who had received antibiotics. When queried if criteria was met for each antibiotic and/or antimicrobial medication prescribed on the line list including how the criteria was met for January 2026, RN P revealed they would need to review each residents Electronic Medical Record (EMR). Upon request to review the monthly summary and analysis for antibiotic use during January 2026, RN P reviewed the Infection Control documentation and revealed an analysis had not been completed. The DON then provided a two-page form titled, Monthly Analysis and Summary/QAPI Committee Infection Prevention/Control Report for January 2026. The form included a section titled Antibiotic Stewardship which detailed, Antibiotic Use Reported to Providers: Yes. Annual Antibiogram (cumulative which summarizes the percentage of individual bacterial pathogens susceptible to specific antimicrobial agents) Review Date: Yes. RN P was asked what Yes meant for the date of the Annual Antibiogram review and was unable to provide an explanation. When queried if they had a copy of the antibiotic report provided to Providers, RN P revealed they did not have a copy of the information. When asked how the facility monitors to ensure residents do not receive antibiotics unnecessarily and those who do require antibiotics receive the appropriate antibiotic for the correct duration without thorough analysis, RN P did not provide further explanation. RN P revealed they stepped into the Infection Control Nurse role at the facility within the last few weeks and had not completed the infection control and antibiotic stewardship data for January 2026 due to the prior Infection Control Nurse leaving the position. When asked, both RN P and the DON verbalized understanding of the importance of summary and analysis of antibiotic usage as part of the infection control and antibiotic stewardship program. Review of facility provided policy/procedure entitled, Antibiotic Stewardship Program (Reviewed/Revised: 12/13/23) revealed, It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. b. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made. ii. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. iv. Monitor during each monthly medication regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic regimen review as requested by the QAA committee. v. Random audits of antibiotic prescriptions may be performed to verify completeness and appropriateness (process measure). vi. Antibiotic use shall be measured by (monthly prevalence, antibiotic starts, and/or antibiotic days of therapy). vii. At least one outcome measure associated with antibiotic use will be tracked as part of QAPI program monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data. viii. A review of the facility's antibiogram will be performed every 18-24 months to guide development or revision of antibiotic use protocols or prescribing practices. 8. Data obtained from antibiotic stewardship monitoring activities is discussed in the facility's QAPI meetings.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents were treated in a dignified manner, call lights were within reach, and needs were met timely for five residents (#4, #42, #45, #53, #122) and a confidential group of residents. Findings include:Resident 4 (R4): On 2/22/26 at 1:16 PM, an observation was made of R4 lying in bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about concerns with care received by the facility. The Resident expressed concerns with call light, when she put it on, sometimes it took a long time for staff to answer. When asked if she had times when the call light was not answered for 30 minutes or longer, the Resident stated, Oh hell yes, especially at nighttime. The Resident reported using the call light for assistance, getting ice or ice water, and for pain medication. The Resident reported that when she used the call light to get pain medication, she would have to wait for them to answer the call light which could be 30 minutes to an hour then have to wait longer to actually get the pain medication. A review of Resident 4 (R4) medical record revealed an admission into the facility on 6/12/25 with diagnoses that included chronic obstructive pulmonary disease, chronic pain, respiratory failure, history of falling and need for assistance with personal care. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 15/15 that indicated intact cognition. Resident 45: On 2/24/26 at 11:51 AM, an observation was made of R45 lying in bed with the bed up in the high position. The Resident was interviewed, answered simple questions and engaged in limited conversation. An observation was made of the Resident's call light on the Geri chair and covered by items in the chair. The call light was positioned over the arm of the chair, and the items were on top of the call light apparatus and cord. The Resident's bed was up in a high position with the head of the bed elevated. The Resident could not see or reach the call light cord or call light apparatus. When asked about the call light not in reach, the Resident stated, It falls on the floor a lot, and that he throws things at the door to get someone's attention. Nurse N was alerted to the call light not in reach. When the Nurse entered the room with the Surveyor, the Resident started asking for his call light. The Nurse placed the call light in R45's reach, clipped it in place and lowered his bed down. When asked if the Resident should have the call light in reach, the Nurse stated, Oh, absolutely he should have had it in reach. A review of R45's MDS revealed a BIMS score of 7/15 that indicated moderately impaired cognition and needed substantial/maximal assistance with personal hygiene, rolling from side to side and was dependent on helper for transfers, dressing and toileting hygiene. Resident 122 (R122): On 2/22/26 at 1:10 PM, an observation was made of R122 lying in bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about concerns with care at the facility. When asked about call light response times, the Resident stated, Sometimes you have to wait for them to answer your call light, I was left on the toilet for 30 minutes. When asked if he has (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had to wait more than 30 minutes, the Resident stated, yes, off and on, sometimes day shift but mostly night shift. The Nurse will answer the light and turn it off and say, 'I will let them know', then you got to wait and wait. I turn the light back on after about 10 minutes of no one showing up. A review of R122's MDS assessment revealed a BIMS score of 15/15 that indicated intact cognition and needed substantial/maximal assistance with toilet transfer and chair/bed to chair transfer and dependent on helper with toileting hygiene. On 2/25/26 at 3:07 PM, Nurse, Unit Manager M was asked about facility policy for responding to call lights. The Unit Manager stated, We should answer as soon as they go off. When asked about call lights in reach for Resident's the Unit Manager reported they should be clipped in reach for the Resident. Resident #53 (R53): A review of Resident 53's (R53) medical record revealed an admission into the facility on 6/27/24 with diagnoses that included hemiplegia and hemiparesis (weakness and paralysis affecting left dominant side), muscle wasting and atrophy, attention and concentration deficit, cerebrovascular disease (decreased blood flow to the brain). A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 00/15 that indicated severe problems with memory or thinking. On 02/23/2026 at 8:12 AM, An observation was made of R53's call light laying on the floor at the head of the bed and not in the residents reach. On 02/23/2026 at 8:18 AM, CNA Q was asked about R53's location of her call light and she said it was on the floor but should not be, she picked it up and clipped it to R53' blanket. Record review of R53's care plan revealed: Focus: Resident has an ADL self-care performance deficit related to generalized weakness. with Interventions that included: Place call light within reach. A record review of the facilities policy titled Call lights: accessibility and timely response revealed: Policy. assure the facility is adequately equipped with a call light at each resident's bedside, toilet and bathing facility to allow for residents to call for assistance. Confidential Group of Residents On 02/23/2026 at 2:38PM, a meeting was held with a confidential group of residents and family. The following concerns were brought up by the group. -The confidential group agreed they all wait a long time to have their call light answered. The confidential group stated, the nursing staff has a habit of coming in the room and turning off the call light without completing the task or they say, I'll be right back and they never come back. The confidential group agree that the nursing staff will then get upset if they turn their call light back on after they leave the room. -The confidential group agrees that their call lights are on the floor a lot or out of reach. -The confidential group are concerned that the nursing staff have personal conversations they can (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hear. Stating they will talk about other residents and can be overheard. The confidential group stated that staff will talk to each other and not to the resident when providing care, often times talking about other residents or their personal lives. The confidential group stated that the staff likes to visit in the room and not complete tasks timely. -A confidential family member was present at the meeting and stated there have been times she will have to call the facility to get her brother help because he cannot reach his call light and is in need of suctioning. The family member stated this occurs a lot on the weekends or after 7:00pm. Resident #42 R42 most recently admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure, ventilator dependence and muscular dystrophy. On 02/24/2026 at 4:11PM, R42 stated that he has limited use of his hands and his call light is a press pad that gets placed on the headrest of his power chair, so he is able to turn it on by moving his head backwards. R42 stated that his call light is out of reach at times and he has to yell to get help.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 2627046. Based on observation, interview and record review, the facility failed to implement and operationalize procedures to ensure that Activity of Daily Living (ADL) care was provided to six residents (#1, #2, #9, #16, #82, and #123) of eleven residents reviewed, resulting in a lack of daily and hygiene care for dependent residents.Findings include:Resident 82 (R82): On 2/22/26 at 12:35 PM, an observation was made of Resident 82 in his room. The Resident was interviewed, answered questions and engaged in limited conversation with some answers/conversation not understood. An observation was made of R82 with facial hair. When asked if he liked to be close shaven or would rather have a beard, the Resident reported he liked a goatee and indicated he liked the mustache, around his mouth and over his chin. When asked about the hair growth that was on his checks, the Resident reported it was long there. An observation was made of R82's fingernails that were long, a couple broken and jagged. The nails were clean underneath. When asked if staff had offered to trim his nails the Resident answered, I don't think so. When asked if he would let them trim them f they offered, the Resident stated, Yeah. A review of R82's medical record revealed an admission on [DATE] with diagnoses that included metabolic encephalopathy, dementia, muscle weakness and difficulty in walking. A review of R82's Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status score of 12/15 that indicated moderately impaired cognition and the Resident needed substantial/maximal assistance with shower/bathe self and dressing and needed partial/moderate assistance with personal hygiene. A review of R82's care plan revealed no focus or intervention for refusal of nail care and a lack of a focus of a care plan for refusals of care. A review of Resident 82's task for the last 30 days for Shower/Bath: (to be given) Tuesday and Friday revealed a shower documented as given on 1/27/26, 2/3/26 and 2/10/26. O 2/25/26 at 2:57 PM, an interview was conducted with the Unit Manager, Nurse (UM) M regarding Resident 82's lack of showers and nail care. The UM observed with the surveyor of Resident 82's long, broken and jagged fingernails. The UM indicated that the Resident has been known to refuse care, and a CNA reported that he last refused his nail care with the last shower. A review of the progress notes with the UM revealed no documentation of refusal of nail care. When asked about facility policy of refusals of care, the UM reported the CNA would notify the nurse and then the nurse would put documentation into the medical record if the Resident continued to refuse the care. A review with the UM of progress notes that lacked documentation of the refusals for some of the showering and nail care was conducted and the lack of a care plan focus for refusal of care. When asked if the Resident should have a care plan for refusals, the UM stated, Yes, absolutely. I will make sure it is in there. Resident #2: On 2/23/26 at 4:01 PM, Resident #2 was observed sitting on the edge of their bed in their room. Upon crossing the doorway into the Resident's room, a rank and offensive odor was immediately noted. The (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	odor was pervasive, overwhelming, and became more intense closer to Resident #2. When queried regarding the care they receive in the facility, Resident #2 indicated some things were okay and some were not so good but did not provide more specific information when asked. One side of the Resident's bed was positioned directly against the wall. A fall mat, with visible tears and holes, was in place on the floor. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses which included bilateral above the knee amputations, diabetes mellitus, cognitive communicative deficit, and end stage renal disease with dialysis dependance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to total assistance to complete Activities of Daily Living (ADLs). Review of Resident #2's Electronic Medical Record (EMR) revealed a care plan entitled, Resident has an ADL self-care performance deficit. Needs 2 staff assist for all ADL and functional mobility. (Initiated: 1/21/26; Revised: 12/30/26). The care plan included the intervention, Bathing: 2 person total assist. Review of Resident #2's EMR Documentation Survey Report for February 2026 revealed the task, Bathing Wednesday and Saturday 2nd Shift. Per the documentation, Resident #2 received the following: - 2/3/26: Scheduled bathing task documentation was blank indicating the task was not completed. - 2/6/26: A bed bath with staff assistance to bathe self, including washing, rinsing, and drying. was provided. - 2/10/26 and 2/13/26: The report detailed the Resident refused any bathing. - 2/17/26: Resident #2 had a bed bath and washed themselves completely independently. - 2/20/26: Scheduled bathing task documentation was blank indicating the task was not completed. Review of progress note documentation in Resident #2's EMR revealed no documentation of attempts to reapproach the Resident following bathing refusals and/or reasons why bathing was not completed on 2/3/26 and 2/20/26. An interview was conducted with the Director of Nursing (DON) on 2/24/26 at 2:50 PM. When queried regarding the overwhelmingly strong odor in Resident #2's room which was stronger nearer the Resident, the DON replied, They had a UTI (Urinary Tract Infection) recently. When queried how much urine Resident #2 produces as they were dependent upon dialysis, a specific answer was not provided. The DON was queried further regarding the pervasiveness of the odor and verbalized that the room would be cleaned. Review of Resident #2's Health Care Provider (HCP) orders and Medication Administration Record (MAR) revealed the Resident received two separate courses of antibiotic therapy in February 2026. One course of antibiotics from 2/6/26 to 2/10/26 and a different antibiotic from 2/11/26 to 2/17/26. Resident #9: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/22/26 at 12:14 PM, an observation was completed of Resident #9. The Resident was in bed, positioned on their back. The Resident had a tracheostomy in place and was receiving mechanical ventilation. Resident #9's eyes were closed and did not respond when their name was spoken. The Resident had visible, dark colored, long chin hairs. Record review revealed Resident #9 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dysphagia (difficulty swallowing), aphasia (difficulty speaking and expressing self verbally), pain, and respiratory failure with tracheostomy (surgically created opening in the neck to the trachea to allow for air exchange) placement and mechanical ventilator (machine which assist and/or breaths for individuals who are unable to breathe for themselves) dependance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and was dependent upon staff for completion of Activities of Daily Living (ADLs.). Review of Resident #9's Electronic Medical Record (EMR) revealed a care plan entitled, Resident has an ADL self-care performance deficit. has bilateral hearing loss, legally blind (Initiated: 6/24/24; Revised: 2/11/25). The care plan included the interventions: - Resident will request to have her nails trimmed but often refuses when staff approach to cut. (Initiated: 4/24/25) - Bed Mobility: 2 Person total assist (Initiated: 6/24/24; Revised: 11/8/24) - Personal Hygiene: 1-person total assist (Initiated: 6/25/24; Revised: 11/8/24) Resident #9 did not have a care plan and/or intervention in place which addressed chin hair. On 2/24/26 at 12:15 PM, Resident #9 was observed in their room in bed. The long, dark colored hairs remained visible on Resident #9's chin. The Resident's hands and fingernails were above the blanket and visible. A dark colored, unknown substance was observed under the fingernails on both of their hands. At 12:21 PM on 2/24/26, an observation of Resident #9 was completed with Registered Nurse (RN) A. When asked about Resident #9's fingernails, RN A confirmed the presence of an unknown dark colored substance under their nails and indicated they would clean the Resident's nails. An interview was conducted with the DON on 2/24/26 at 2:50 PM. When queried regarding the substance under Resident #9's fingernails, the DON verbalized staff should ensure the Resident's hands and fingernails are clean. When asked about the long, dark colored chin hair, the DON replied, I think chin hair is on the care plan. Resident #9's care plan was reviewed with the DON at this time. The DON confirmed the Resident did not have a care plan and/or interventions related to care of chin hair and indicated they would address the concern. Resident #16: On 2/22/26 at 12:09 PM, Resident #16 was observed in their room. The Resident was in bed, positioned on their back with their head turned slightly to the left. Resident #16 had a tracheostomy and was receiving mechanical ventilation. Resident #16's lips were dry and cracked. An unknown, dried substance was present around the Resident's mouth and left cheek. Various areas of unknown (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	light brown to brown colored areas were present on the Resident's pillow and blankets. Resident #16's eyes were closed and mucous was present in the corners of both eyes. Record review revealed Resident #16 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included heart failure, dysphagia, gastrostomy (surgically created opening in the abdomen to the stomach for the administration of nutrition and medications), and respiratory failure with tracheostomy placement and mechanical ventilator dependance. Review of the MDS assessment dated [DATE] did not include a cognitive assessment but specified the Resident was dependent upon staff for completion of all ADLs. Review of Resident #16's EMR revealed a care plan entitled, Resident has an ADL self-care performance deficit. (Initiated: 7/22/24; Revised: 5/3/25). The care plan included the intervention, Personal Hygiene: 1-person total assist (Initiated: 8/8/23; Revised: 8/9/23). On 2/24/26 at 11:17 AM, Resident #16 was observed in their room. The Resident was in bed with their head positioned slightly to the left. Dried and moist mucous was present on both sides of the Resident's mouth. An interview was completed with the DON on 2/24/26 at 3:15 PM. The DON was informed of observations of Resident #16. When asked about Resident #16's observed lack of hygiene, the DON stated, That is not okay. Resident #123: On 2/23/26 at 9:41 AM, Resident #123 was observed in their room in bed. The Resident's hair was long with a greasy appearance. Various sizes of visible chunks of an unknown substance were present in the Resident's hair. Resident #123 had a long, unkempt beard. The head of the Resident's bed was elevated at 15 degrees, and they did not have a pillow under and/or near their head. An interview was completed at this time. Resident #15 was asked if they did not like using a pillow and revealed they do. When asked why they did not have a pillow, Resident #15 did not provide a response. When queried if they liked having a beard, Resident #123 responded that they liked to be shaved. When asked if they had a beard now if they preferred to be shaved, Resident #123 replied that the facility staff have not offered to assist and they are unable to shave themselves. Resident #123's right upper extremity appeared to be flaccid, and their hand was in a fist. When asked if they were able to move their right arm, Resident #123 indicated they could not. When queried if they were able to open their right hand, the Resident responded that it was stuck and they could not move and/or open it. Record review revealed Resident #123 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included heart disease, dependence upon supplemental oxygen, cerebral infarction (stroke) with resulting dysphagia (difficulty swallowing), aphasia (difficulty with speech), and right sided hemiplegia and hemiparalysis (one-sided paralysis). Review of the MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required moderate to total assistance to complete ADLs with the exception of oral care/eating. Review of Resident #123's EMR revealed a care plan entitled, Resident has an ADL self-care performance deficit. (Initiated: 10/3/24; Revised: 12/15/25). The care plan included the intervention, Personal Hygiene: 1-person extensive assist (Initiated and Revised: 9/28/23). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/24/26 at 3:16 PM, an observation of Resident #123 was completed with the DON. Resident #123 was asked if they preferred a beard or be shaved and informed the DON they preferred to be shaved. Resident #123's right hand remained in a fist. When queried regarding hand and fingernail care for the Resident's right hand, the DON lifted the Resident's hand for observation. The fingernails on Resident #123's right hand were long, unkempt, and digging in the skin on their palm. When asked, Resident #123 verbalized their hand hurt from their fingernails digging into the skin. After exiting the Resident's room with the DON, an interview was completed. When asked about the cleanliness of the Resident, being unshaven when they prefer to be shaved, and their fingernails, the DON indicated that it was not acceptable and they would address the concerns immediately. Resident #1 (R1): R1 was admitted to the facility on [DATE] with diagnoses that include a history of cerebral infarction, cognitive communication deficit and acute respiratory distress syndrome. On 02/22/2026 at 12:57PM, during an interview with R1, it was observed that R1 had long fingernails. R1 was asked if they like their fingernails that long. R1 stated no, they are a little long for me. R1 was asked if the staff had offered to cut her fingernails or if she had asked to have her fingernails cut. R1 stated, I have asked for them to be cut, and they didn't cut them and the staff doesn't offer to cut them. R1 was asked if they would accept getting their nails cut if staff offered. R1 stated yes, I would accept it if they did. R1 stated that she has not had her nails cut once since being in the facility. On 02/22/2026 at 01:05PM, record review of the electronic medical record (EMR) did not reveal documentation of nail care being completed for R1. Review of the EMR revealed a care plan for activities of daily living (ADL), R1 requires extensive assistance of one staff member for personal hygiene care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain nebulizer equipment (a medical device that turns liquid medication into a fine mist to be inhaled directly into the lungs for treatment of respiratory conditions) in a sanitary manner for four residents (#16, $#84, #118 and #119), of seven residents reviewed for respiratory care and ventilator/tracheostomy care. Findings include:Resident #16: On 2/22/26 at 12:09 PM, Resident #16 was observed in their room. The Resident was in bed, had a tracheostomy and was receiving mechanical ventilation. The Resident did not respond when spoke to. A connected nebulizer administration set dated 1/25 was present in a clear bag hanging behind the ventilator machine. A visible, dried, crystalized substance was observed in the medication administration chamber of the nebulizer. Record review revealed Resident #16 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included heart failure, dysphagia, gastrostomy (surgically created opening in the abdomen to the stomach for the administration of nutrition and medications), and respiratory failure with tracheostomy placement and mechanical ventilator dependance. Review of the MDS assessment dated [DATE] did not include a cognitive assessment but specified the Resident was dependent upon staff for completion of all ADLs. On 2/23/26 at 8:50 AM and on 2/24/26 at 11:17 AM, Resident #16 was observed in their room in bed. The nebulizer administrator set remained connected in a plastic bag with a dried, crystalized substance in the medication administration chamber of the nebulizer. Resident #84: On 2/22/26 at 12:19 PM, Resident #84 was observed in their room in bed. The Resident was receiving respiratory support via tracheostomy and mechanical ventilation. A nebulizer administration set was observed behind the ventilator in a clear plastic bag. The nebulizer administration set was connected, and a dried whitish colored substance was observed in the medication administration chamber. Record review revealed Resident #84 was most recently admitted to the facility on [DATE] with diagnoses which included vegetative state, gastrostomy, respiratory failure, and ventilator dependence with tracheostomy. Review of the MDS assessment dated [DATE] did not include a cognitive assessment and revealed the Resident was dependent upon others for all ADLs. On 2/23/26 at 8:21 AM, an observation of Resident #84 was completed in their room. The nebulizer administration set remained connected and hanging behind the ventilator in a clear plastic bag. The same dried, whitish colored substance was observed in the medication administration chamber. Resident #118: Resident #118 was observed in their room on 2/22/26 at 12:32 PM. The Resident was in bed, positioned on their back. Resident #118 was receiving mechanical ventilation via tracheostomy and did not respond when spoke to. A connected nebulizer administration set was present in a clear bag hanging behind the ventilator machine. A visible, dried substance was observed in the medication administration chamber of the nebulizer. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/23/26 at 8:42 AM, an observation of Resident #118 was completed. The Resident was in bed, positioned on their back. Mechanical ventilation via tracheostomy was in place. The connected nebulizer administration set remained hanging in a clear bag behind the ventilator, and the visible dried substance was still present in the medication administration chamber. Record review revealed Resident #118 was originally admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke) with resulting right sided hemiplegia/hemiparalysis (one sided paralysis) and dysphagia (difficulty swallowing), dementia, gastrostomy (surgically created opening in the abdomen to the to stomach for the administration of nutrition and medications), neuromuscular dysfunction of the urinary bladder, respiratory failure with tracheostomy (surgically created opening in the neck to the trachea to allow for air exchange) placement and mechanical ventilator (machine which assist and/or breaths for individuals who are unable to breathe for themselves) dependance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and dependent upon staff for completion of all Activities of Daily Living (ADLs). An interview was completed with Respiratory Therapist (RT) O on 2/24/26 at 4:36 PM. When queried regarding procedure for care of nebulizer equipment following treatment administration, RT O stated, We empty and then shake, put back together and in bag. An observation of Resident #16's nebulizer administration set was completed with RT O at this time. When queried, RT O confirmed the present of the crystalized substance in the medication administration chamber and stated, Should not be like that. When asked if they rinse the medication administration chamber and let it air dry, RT O replied, They are disposable and we get a new one every week, so we don't do that. An interview was completed with the Director of Nursing (DON) on 2/24/26 at 4:38 PM. When queried regarding the facility policy/procedure related to care of nebulizer equipment following treatment administration, the DON stated, We rinse and air dry. Resident 119 (R119): On 2/22/26 at 10:27 AM, an observation was made of Resident 119 lying in bed watching a hockey game on the television. The Resident was interviewed, answered questions and engaged in conversation. The Resident had a tracheostomy and was connected to a ventilator. An observation was made of nebulizer apparatus that was assembled together and stored inside a bag that was hanging on oxygen supply on the wall. The nebulizer was in a bag, and the medication chamber was observed to be stored moist. A review of R119's medical record revealed an admission into the facility on 1/9/26 with diagnoses that included acute and chronic respiratory failure with hypoxia, dependence on respirator (ventilator) status, stroke and tracheostomy status. On 2/24/26 at 4:39 PM, an observation was made with the Director of Nursing (DON) of R119's nebulizer treatment equipment in the Resident's room. The nebulizer was stored in the bag and assembled together. The DON took out the nebulizer equipment out of the bag and the medication chamber was observed with moisture and multiple whiteish crystals on the inside of the medication chamber. The DON removed the nebulizer equipment and rinsed it out. When asked about facility policy on storage of the nebulizer equipment, the DON reported it should be cleaned out and set on a barrier to dry. When asked if it should have crystals in the medication chamber, the DON said, No, it shouldn't.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure advance directives were completed appropriately and the care plan for advance directives was updated for one resident (R130) of six residents reviewed for advance directives, resulting in one cognitively impaired resident changing their code status and an inaccurate care plan. Findings include:Resident #130 (R130): R130 admitted to the facility on [DATE] with diagnoses that include peripheral vascular disease, heart disease, hypertension and cognitive communication deficit. R130 expired at the facility on [DATE]. On [DATE] at 10:18AM, record review revealed a physician's order for do not resuscitate (DNR) dated [DATE] at 10:39am. Record review also revealed a physician's order for Full Resuscitate, dated [DATE] and it was discontinued on [DATE], when the DNR order was placed. On [DATE] at 10:21AM, the care plan for R130 was reviewed, a care plan for advance directives was present and stated, Resident has chosen not to formulate advanced care planning. The care plan was dated [DATE] and had not been updated with changes. On [DATE] at 10:30AM, review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. On [DATE] at 11:03AM, an interview was conducted with Social Worker (SW J. SW J was asked what the process is for completing advance directives for residents who are cognitively impaired. SW J said if a resident is cognitively impaired, we will get a competency from the physician. SW J stated that R130 had a BIMS of 11 on admission, which is in the moderate area. SW J stated that R130's advance directive at that time was to be a DNR and that was on [DATE]. SW J stated that R130 was seen by psych in October, her psych note does not indicate that she was incompetent. SW J stated, we do have forms for decision making, however this resident does not have one in the chart. The psych group did not indicate that she needed this form filled out. SW J was asked why R130 was able to sign her own paperwork for DNR on [DATE] if her BIMS was documented as a 3, indicating severe cognitive impairment. SW J stated, to the best of my knowledge, after the nursing staff talked with R130, they felt she was cognitively intact and able to make that decision to be a DNR. Then I approached her and filled out the paperwork with her to be a DNR. SW J was asked what they would do in a code status situation where a resident has a low score on the BIMS, indicating severe cognitive issues. SW J stated we would check the BIMS score for a score of zero to seven (0-7), then we are going to have the doctor look at them for a competency, then I would call the family and have them come in and we would discuss the code status. SW J stated we didn't have any competency form to go off of and that is why she was able to make the decision on code status. SW J was asked if they thought R130 should have had a competency check prior to signing the DNR status and if family should have been involved in the decision making. SW J stated, I agree that we should have completed the competency for her before deciding on a code status. At the end of the conversation SW J provided this surveyor with a completed BIMS, dated [DATE] with a score of 11, indicating mild cognitive impairment. On [DATE] at 1:21PM, record review of the electronic medical record (EMR) revealed there was no documentation indicating a conversation had taken place to discuss code status with R130 or the responsible party. On [DATE] at 1:25PM, record review of the EMR revealed a progress note dated [DATE] at 02:50AM that read, resident confused at baseline, calling out, frequently using call light. Resident has call light in hand and states that she doesn't need anything but wants the light to remain on. Resident attempted to self-transfer several times, redirection and education provided. Further education needed. On [DATE] at 10:10AM, record review of the EMR revealed a psychiatry initial evaluation, which states that R130 has a BIMS of 3. Review of the policy titled, Resident's Rights Regarding Treatment and Advance Directives, revealed: Policy Explanation and Compliance Guidelines: 4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determined not to have decision making capacities.8. Decision's regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that physical restraints were not used for staff convenience for one resident (Resident #118) of one resident reviewed, resulting in restriction of mobility. Findings include: Resident #118:Resident #118 was observed in their room on 2/22/26 at 12:32 PM. The Resident was in bed, positioned on their back. The bed was at normal height and fall mats were in place. The two upper side rails on the Resident's bed were raised. Resident #118 was receiving mechanical ventilation via tracheostomy and did not respond when spoke to. Record review revealed Resident #118 was originally admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke) with resulting right sided hemiplegia/hemiparalysis (one sided paralysis) and dysphagia (difficulty swallowing), dementia, gastrostomy (surgically created opening in the abdomen to the to stomach for the administration of nutrition and medications), neuromuscular dysfunction of the urinary bladder, respiratory failure with tracheostomy (surgically created opening in the neck to the trachea to allow for air exchange) placement and mechanical ventilator (machine which assist and/or breaths for individuals who are unable to breathe for themselves) dependance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and dependent upon staff for completion of all Activities of Daily Living (ADLs) including bed mobility. The MDS further detailed the Resident did not have any restraints in place and bed rails restricting movement were not in place. On 2/23/26 at 8:42 AM, an observation of Resident #118 was completed in their room. The Resident was in bed, positioned on their back. Resident #118 was receiving mechanical ventilation via tracheostomy. The bed was a hospital bed, positioned at normal height with all four separate bed rails raised. A gap was present on each side of the bed between the upper and lower bed rails. Fall mats were observed on both sides of the bed and the Resident was observed to have a contracture in their left upper extremity/hand. Review of Resident #118's Electronic Medical Record (EMR) revealed a care plan entitled, Resident is at risk for falls/injury. has decreased strength and endurance with poor balance and coordination. non ambulatory. total assist with care for all ADL and functional mobility (Initiated and Revised: 11/17/23). The care plan included the interventions:- 5/15/24- fall mat to bilateral sides of resident's bed (Initiated: 5/16/24; Revised: 8/1/24)- Low bed (Initiated: 11/16/23)- Discuss and document the risks and benefits, when evaluating bed modifications, and any other concerns or issues related to the bed modification with the resident/representative (Initiated: 10/2/25)- Scoop mattress LAL (Low Air Loss) to provide resident with tactile barrier to improve spacial awareness (Initiated and Revised: 4/19/24)- [NAME] bed (brand)- side rails for safety and support (Initiated and Revised: 10/2/25)The care plan did not indicate the number of side rails which should be raised/elevated. Review of Progress Note documentation in Resident #118's EMR revealed no documentation pertaining to use of side rails. A scanned document titled, Informed Consent for Use of Bed Rails was present in Resident #118's EMR. The form detailed, Resident Overview: What assessed medical needs would be addressed by the use of bed rails for this resident? Immobility; Mobility loss. What are the possible benefits of bed rail use and what is the likelihood of these benefits: Increased bed mobility, safety, security. What are the possible risks of bed rail use for this resident and how will these risks be mitigated: entrapment. Alternatives to bed rails have been attempted but failed to meet this resident's needs, or were not attempted because they were considered to be inappropriate, describe PT (Physical) therapy. Recommendation. Full side rail Right. Left. recommended at all times when resident in bed. The form indicated verbal consent was obtained by Resident #118's representative on 9/17/25. On 2/24/26 at 11:56 AM, an observation of Resident #118 in their room was completed. The Resident was in bed with three side rails elevated including both upper rails and the bottom left rail (closest to room door). An interview was completed with (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant (CNA) C on 2/24/26 at 11:59 AM. When queried how many side rails were supposed to be raised on Resident #118's bed, CNA C replied, Probably two. CNA C was asked how they know how many side rails should be raised/elevated and stated, I assume supposed to be two because it would be restraint with more side rails raised/elevated. When queried regarding the number of side rails currently raised/elevated on Resident #118's bed, CNA C stated, There were three (side rails) up when I got here so I just left them. CNA C was asked why there were three side rails raised and replied, (Resident #118) wiggles. With further inquiry CNA C verbalized three side rails were raised so Resident #118 don't wiggle off the bed. When queried why the bed rails were elevated instead of completing frequent checks to ensure appropriate positioning in bed, CNA C did not provide an explanation. CNA C was then informed of observation of all four side rails being elevated on 2/23/26 and asked if they knew why the rails would be elevated. CNA C revealed staff will raise the bed rails so Resident #118 does not wiggle down and attempt to put their leg over the side of the bed. On 2/24/26 at 12:02 PM, an interview was conducted with Registered Nurse (RN) A. When queried how they know how many side rails are supposed to be raised/elevated on a resident's bed, RN A responded, It should say on the Kardex. When asked how many side rails Resident #118 should have raised/elevated, RN A reviewed the Resident's Kardex in the EMR and responded, It doesn't say. RN A then stated, I would say two (side rails elevated) because otherwise it would be a restraint. At 12:10 PM on 2/24/26, the same three side rails remained elevated on Resident #118's bed. An interview was completed with the Director of Nursing (DON) on 2/24/26 at 2:42 PM. When queried how many side rails Resident #118 should have raised/elevated on their bed, the DON stated, Two. Observations of Resident #118 having three and four side rails raised/elevated were reviewed with the DON at this time. When queried regarding the use of three or four side rails, the DON stated, That would be a restraint. The DON was then queried regarding the reason staff were raising three to four side rails and replied, I can only assume why staff were doing that and indicated they did not have an answer. On 2/24/26 at 3:51 PM, a follow up interview was completed with the DON. When queried regarding the Informed Consent for Use of Bed Rails form in Resident #118's EMR pertaining to full rails, the DON replied that the consent was for the use of the two upper bed rails only. Review of facility policy/procedure entitled, Restraints (Reviewed/Revised: 10/26/23) revealed, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. 1. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). An evaluation will be completed to determine the medical symptom requiring the device and to determine the least restrictive device to treat the symptom. 2. Restraints with locking devices shall not be used. 6. Physical restraints shall only be used on the signed order of a physician, except in an emergency. Care plans which include the use of physical restraint for behavior control shall specify the behavior to be eliminated, the method to be used, and the time limit for the use of the method. Review of facility policy/procedure entitled, Proper Use of Bed Rails (Reviewed/Revised: 3/20/24) revealed, It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance. Ongoing Monitoring and Supervision: 15. The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices. This should be evidenced in the residents' records, including their care plan, including, but not limited to, the following information: a. The type of specific direct monitoring and supervision provided during the use of the bed rails, including documentation of the monitoring. 16. Responsibilities of ongoing monitoring and supervision are specified as follows: a. Direct care staff will be responsible for care and treatment in accordance with the plan of care.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents' Minimum Data Set (MDS) assessments accurately reflected the residents' status for one resident (Resident #32) of one resident reviewed for MDS discrepancies.Findings include:Resident #32 (R32):A review of R32's medical record revealed an admission into the facility on [DATE] with diagnoses that included dementia, sciatica, and the history of falling. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 3/15 that indicated severe problems with memory or thinking.A record review of R32's MDS assessment dated [DATE], section N-Medications indicated: N0300. Injections: Record the number of days that injections of any type were received during the last 7 days or since admission/entry. entry 7 (days). and N0350. A. Insulin injections: Record the number of days that insulin injections were received during the last 7 days. entry 7 (days); B. Orders for insulin: Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders. entry 0 (days). That Indicated R32 had an order for and received insulin without a change in orders by a physician. The MDS assessment Signature of RN assessment coordinator verifying assessment completion was signed on 01/22/2026 by MDS Nurse C.On 02/24/2026 at 8:00AM, During medication pass an observation of R32, no insulin was given and observed there was no insulin ordered on the medication administration record (MAR) for R32.A record review of R32's Orders revealed no orders for insulin. R32's medical chart did not include a diagnoses that indicated the need for insulin.On 02/25/2026 at 10:45AM, During an interview with MDS Nurse S was asked to review MDS assessment dated [DATE] for R32 and she confirmed it indicated it identified 7 days of insulin injections with 0 changed orders for the identified time period. MDS Nurse S was asked to review and confirm R32's medical diagnoses that required insulin use, she could not. MDS Nurse S was asked to review orders for R32 for insulin, she could not. MDS Nurse S was asked to review progress notes that indicated use of insulin for R32, she could not. MDS Nurse S reviewed the MAR for R32 and verified no insulin had been administered to R32. MDS Nurse S confirmed that R32's MDS assessment for 01/19/2026 was not accurate. MDS Nurse S stated I have time to correct it and resubmit it to the state and that she was doing that as we spoke.On 02/25/2026 at ~(approximately) 11:25AM, MDS Nurse S produced a revised CMS submission report for NH MDS 3.0 validation report with ID #35344505 that had been accepted on 02/25/2026.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement planned interventions for contracture management for one resident (Resident #16) of three residents reviewed resulting in lack of application of splints. Findings include:Resident #16:On 2/22/26 at 12:09 PM, Resident #16 was observed in their room. The Resident was in bed, positioned on their back with their head turned slightly to the left. Resident #16 had a tracheostomy and was receiving mechanical ventilation. The Resident's eyes were closed, and they did not respond to verbal stimulation. Resident #16's hands were bent towards their inner arm at the wrist joint as though contracted and their legs were bent at the knees. The Resident did not have any devices including splints/braces in place on their upper and/or lower extremities. Record review revealed Resident #16 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included heart failure, right and left knee contractures, gastrostomy (surgically created opening in the abdomen to the stomach for the administration of nutrition and medications), and respiratory failure with tracheostomy placement and mechanical ventilator dependance. Review of the MDS assessment dated [DATE] did not include a cognitive assessment but specified the Resident was dependent upon staff for completion of all ADLs. The MDS further detailed the Resident had impaired Range of Motion (ROM) in both upper and lower extremities. Review of Resident #16's Electronic Medical Record (EMR) revealed a care plan entitled, Resident would benefit from a restorative splinting program related to contracture, decreased strength in extremities, limitation in range of motion (Initiated: 7/24/25). The care plan included the intervention, Donn sidelyn (sic) leg and knee abductor wedge, left hand splint and left elbow support and remove after 4-5 hours. Continue with daily skin checks as protocol of facility. Perform hand hygiene daily prior to placement of orthotic. Position with pillow on left side of knee to promote neutral position (Initiated: 7/24/25; Revised: 10/16/25). On 2/24/26 at 11:17 AM, Resident #16 was observed in their room. The Resident was in bed with their head positioned slightly to the left. Splints were in place on both of the Resident's arms by their wrists. The Resident's knees remains bent at their knees with no devices and/or braces in place. - Restorative Nursing: PROM (Passive Range of Motion)-BLE (Bilateral Lower extremities) move in all planes and motions to each extremity and each joint with a goal of 10 reps and 2 sets each (as tolerated) 3-5 days/week (Ordered: 1/8/26). Review of Resident #16's Health Care Provider (HCP) Orders and Documentation Survey Report for February 2026 (from 2/1/26 to 2/24/26) revealed the following:- Restorative Nursing: Splint/Brace Assistance (12h) Donn sidelyn leg and knee abductor wedge, left hand splint and left elbow support and remove after 4-5 hours. Continue with daily skin checks as protocol of facility. Position with pillow on left side of knee to promote neutral position.Per the legend, documentation of the code 4 meant the task was not completed. The task was documented as not completed on 2/3/26, 2/6/26, 2/7/26, 2/10/26, 2/13/26, 2/21/26, 2/22/26 Day Shift.On Night Shift, the task was documented as not completed 22 out of 24 times.There was no documentation (blank) of the task being completed on 2/2/26, 2/16/26, 2/17/26, and 2/18/26 Day Shift. On 2/24/26 at 2:43 PM, an interview was conducted with the Director of Nursing (DON). When queried regarding observations of Resident #40 not having their brace in place as ordered and documentation indicating the task was not completed, the DON indicated staff should complete the task and document as completed. Review of facility policy/procedure entitled, Restorative Nursing Programs (Reviewed/Revised: 1/1/22) revealed, Restorative documentation requirements include. Documentation of implementation should be completed on the Restorative Service Delivery Record or EMR as applicable. This includes each description of the intervention or modality to be provided. Time in minutes each time provided. Staff initials each time provided. Comments if refused, withheld or change in status (improvement/decline) as applicable.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that tube feeding was administered per professional standards of practice and the plan of care for one resident (Resident #40) of two residents reviewed. Findings include: Resident #40: On 2/23/26 at 10:40 AM, Resident #40 was observed in their room. The Resident was in bed, positioned on their back. The head of Resident #40's bed was elevated at 17 degrees per protractor tool, and they were receiving tube feeding via infusion pump at a rate of 43 milliliters (mL) per hour. At 10:47 AM on 2/23/26, Registered Nurse (RN) Z was asked to come into Resident #40's room. When asked how high the head of the Resident's bed was elevated, RN Z stated, I don't know. 20 or 30 degrees, I'm not good at that. RN Z was then asked was the head of the head should be elevated to when a resident is receiving tube feeding and replied, 30 degrees in a questioning tone. RN Z proceeded to elevate the head of Resident #40's bed and exit the room. Record review revealed Resident #40 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebrovascular disease, skin transplant, gastrostomy (surgically created opening in the abdomen to the stomach for the administration of nutrition and medications), and colostomy (surgically created opening in the abdomen to the colon to redirect fecal waste into an external bag). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and required total assistance with mobility and ADLs with the exception of maximum assistance for oral hygiene completion. A review of Resident #40 Electronic Medical Record (EMR) revealed a care plan entitled, Resident has an impaired gastrostomy status related to gastrostomy tube for enteral feeding. (Initiated: 2/24/25; Revised: 7/11/25). The care plan included the intervention, HOB (Head of Bed) >30 (degrees) when tube feed is being administered. Encourage resident to stay upright for a short time after meals (Initiated and Revised: 2/24/25). An interview was conducted with the Director of Nursing (DON) on 2/24/26 at 4:15 PM. When queried how high the head of the bed should be elevated when a resident is receiving tube feeding, the DON responded that it should be elevated to a minimum of 30 degrees. The DON was informed of observation involving the head of Resident #40's bed and interview with RN Z. The DON responded that RN Z is new and they will educate them. A policy/procedure related to tube feeding administration was requested at this time but not received by the conclusion of the survey.