STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235264	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ely Manor	1200 Ely St Allegan, MI 49010

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #1234837.Based on interview, and record review, the facility failed to ensure residents were treated with dignity and respect in 1 (Resident #100) of 3 resident reviewed for dignity, resulting in a staff member refusing to assist Resident #100 with care needs Findings include:Review of an admission Record revealed Resident #100 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression (persistent sad mood with loss of interests), anxiety disorder (condition characterized by excessive and persistent worry), chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breath) and chronic systolic heart failure (condition in which the heart's main pumping chamber can't pump enough blood to meet the body's needs).Review of a Minimum Data Set (MDS) assessment for Resident #100 with a reference date of 4/29/25, revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #100 was mildly cognitively impaired.Review of a Care Plan for Resident # 100 with a reference date of 3/17/25, revealed a focus/goal/interventions of: Focus: (Resident #100) has experienced trauma at some point the past. Goal: Will feel safe in the current situation. Interventions: .Establish and maintain a trusting relationship.Maintain a calm non-threatening relationship by listening to the resident.move slowly and avoid sudden movements. provide reassurance to the resident that she is safe and the facility is doing what is needed to maintain safety for all.In an interview on 7/21/25 at 2:48pm, Family Member (FM) V reported Resident #100 voiced concerns several times that the staff would not help her with care tasks and Resident #100 voiced she was worried she would not get the care she needed. FM V reported Resident #100 told her one time a staff member left her on the toilet and refused to help her, and that was she did not trust the staff as a result.In an interview on 7/21/25, at 4:05pm, Licensed Practical Nurse (LPN) II reported she was Resident #100's nurse on 4/21/25. LPN II reported as she stood midway down the hall on 4/21/25 at approximately 11:00am, she saw Certified Nursing Assistant (CNA) NN storm out of Resident #100's room. CNA NN quickly approached LPN II, was out of breath, sweating, had a reddened face and furrowed brow when she said, I can't take care of her (Resident #100)! in an angry tone of voice. LPN II reported she immediately went to Resident #100's room and found her sitting on the toilet, crying, frustrated and sad. LPN II reported Resident #100 said she had requested CNA NN get her 2 basins of water so she could wash herself up and when she did, CNA NN became very angry, shoved a walker that was in the room, told Resident #100 could walk and could do it herself and refused to help her. LPN II reported Resident #100 calmed down after being reassured and LPN II provided the basins she needed. LPN II reported she felt CNA NN's actions toward Resident #100 were very unreasonable and constituted abuse. LPN II reported she immediately reported the incident to management.Review of an Incident Report for Resident #100 with a reference date of 4/21/25 at 11:00am revealed Incident Description: Staff nurse reported to this nurse manager that the resident voiced she had concerns related to her caregiver. Resident description: She (CNA NN) seemed to have an attitude.she said she saw me walk in my room before and I could do it, but I can't. I need help and I can't do it myself. It was warm in my room, and I asked to change clothes.she wouldn't help me change my pants into shorts.Review of an Incident Investigation Report with a reference date of 4/21/25 at 12:13pm revealed Staff member spoke rudely to a resident and would not assist her.Review of an Investigation Report with a reference date of 4/28/25 revealed (Resident #100)stated (CNA NN) was rude and would not listen to me or help me and was upset.(Resident #100) reports CNA swung a wheelchair around quickly, hitting the toilet with the wheelchair and stated If you are going to have a problem, I'll just get you into the chair.(Resident #100) states during care CNA.refused to wash her up and.refused to change her pants.(CNA NN name omitted) states nothing happened.during the interview (CNA NN) ignored questions. answering questions with remarks unrelated to the questions.denies any further behaviors or denial of care.Intervention: (CNA NN) was terminated due to allegations of neglect.Attempts to contact CNA NN were not successful at the time of the completion of the survey.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2563197 and 2564437Based on interview and record review, the facility failed to ensure an incident of neglect (unsafe environment) was reported accurately to the State Agency in 1 of 1 resident (R108) reviewed for reporting, resulting in inaccurate information being reported regarding an incident to the State AgencyFindings include:According to the Minimum Data Set (MDS) dated [DATE], R108 scored 9/15 (moderately cognitively impaired) on her BIMS (Brief Interview Mental Status). R108 was occasionally incontinent and had diagnoses that included right artificial knee joint, cognitive communication deficit, and a history of falling. Section J-Fall History on Admission/Entry or Reentry, indicated R108 had two or more falls since admission or prior assessment with no injury. Section GG-Functional Abilities and Goals indicated a wheelchair was used for mobility. Review of R108's Emergency Medical Service (EMS) Run-Sheet dated 7/2/25 revealed, .Dispatch Reason.penetrating trauma.impalement.musculoskeletal/skin.back.trauma injury. fall.sacral-midline.puncture/stab wound.patient was attempting to get out of bed despite being wheelchair bound, when she fell on the L-shaped corner piece of her metal bed frame.On EMS arrival patient was laying on her right side, staff members had lifted her off the metal piece and laid her on the floor. There was a large, coagulated pool of blood.the post had held her up off the floor. Review of R108's 5th District EMS Field Notes dated 7/2/25 reported the resident was impaled by metal bed frame approximately 3-4 inches. Review of R108's Trauma/Surgical Critical Care History and Physical dated 7/2/25 revealed, .brought in as a Tier I Trauma.suffering a mechanical ground-level fall with her left buttock landing onto her metallic bed frame.3 to 4 inches of the exposed bed frame had entered the patient's soft tissue of her left buttock.noted to be fair amount of exsanguination and blood loss.some form of injury to her anal canal or rectum.complaining of left gluteal and buttock pain.Physical Assessment.anorectal 4 cm radial laceration outside the anoderm in the left lateral position with extruding subcutaneous fat and blood.there is a comminuted fracture of the left inferior pubic ramus and ischial tuberosity with surrounding subcutaneous gas.soft tissue hematoma in the left buttock/perineal region.warrant further exploration and endoscopy.admit.Operating today for rectal exam under anesthesia, flexible sigmoidoscopy, possible exploratory laparotomy, possible bowel resection. Review of Investigation authored and provided by NHA A on 7/2/25 reported at approximately 5:40 AM, a nurse was in the hallway near the resident's room and heard a noise. Upon entrance to the room, the nurse noticed the resident had a fall at the end of her bed. The resident was sent to the ER for further evaluation. Once evaluated in the ER, the facility learned that (R108) had a fracture to her left inferior pubic ramus. It was noted the Investigation did not mention the penetrating trauma/impalement of a metal bracket to the resident's buttock that caused bleeding. During an interview and record review on 7/22/25 at 1:20 PM, Nursing Home Administrator (NHA) A reported information in an investigation/summary report sent to the State Agency should include apparent injuries that were linked to the incident. NHA A further stated, I did not omit (R108's) injuries, I just didn't know she had a fracture until after she went to the ER for evaluation. When asked why she did not report R108 was impaled with a metal bracket from her bed and there was blood loss, NHA A did not have an answer.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide individualized activities designed to support the psychosocial well-being of 1 of 3 Residents (Resident #104) reviewed for activities, resulting in a potential for feelings of social isolation, loneliness, anxiety and boredom. Findings include:Review of Revolutionizing the Experience of Home by Bringing Well-Being to Life: The [NAME] Alternative Domains of Well-Being, Copyright 2012, Rev. 2020, revealed The [NAME] Alternative defined one domain of wellness as Connectedness- the state of being connected; alive.engaged, involved. Without meaningful interactions the individual can become disconnected.develop loneliness, helplessness, and boredom.Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: anxiety disorder (persist feelings of worry that interfere with daily life), stroke (damage to the brain from interruption of its blood supply), and pressure injury to heels, sacral region(bottom).Review of a Care Plan for Resident #104 with a reference date of 1/29/25, revealed a focus/goal/interventions of: (Resident #104) has a psychosocial well-being problem actual r/t (related to) anxiety disorder, aphasia (loss of ability to verbally communicate) .Goal: Will have no indications of psychosocial well-being problem by review date. Interventions.invite and encourage participation in activities of interest and provide room [ROOM NUMBER]:1 activities as needed.Review of a Minimum Data Set (MDS) assessment for Resident #104 with a reference date of 3/1/25 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated Resident #104 was not able to complete the interview. Section GG revealed Resident #104 was dependent for bed mobility and transferring from bed to wheelchair. Section M revealed Resident #104 had one or more unhealed pressure ulcers. In an interview on 7/10/25 at 2:52pm, Family Member (FM) U of Resident #104 reported she was concerned because the resident received very little social interaction or stimulation and spent most of his time alone. In an interview on 7/22/25 at 8:47am FM U reported prior to his admission to the facility, Resident #104 enjoyed hunting, fishing, spending time outdoors, being with his pets (cat and dog), caring for his chickens, watching television, being around people, listening to music of all types both in Spanish and English, and doing mechanical work. FM U described Resident #104 as the type of person that was always on the move. FM U reported she felt it would improve Resident #104's quality of life if the facility assisted him with going outdoors regularly, ensured he had social interaction, and gave him objects to manipulate with his hands. FM U also reported that Resident #104 was Catholic and described practicing his faith as very important to him. FM U reported the Activities Director had not inquired about Resident #104's usual leisure interests and his religious preferences.During an observation on 7/14/25 at 11:12pm, Resident #104 was awake, lying in bed in a quiet, darkened room. The privacy curtain was partially pulled around his bed. Resident #104's eyes were cast toward the bare wall. Resident #104 had no personal belongings or pictures within his view. The window was not within his view. During an observation on 7/15/25 at 9:27am, Resident #104 was alone, lying awake in his bed. The room was quiet, lights turned off. During an observation on 7/21/25 at 9:14am, Resident #104 was alone, lying asleep in his bed.During an observation on 7/15/25 at 12:48pm, Resident #104 was alone, lying awake in his bed. The room was quiet. Resident #104's eyes were directed toward a bare wall as he fidgeted with the tab of his incontinence brief. During an observation on 7/16/25 at 10:04am, Resident #104 was alone, lying awake in his bed.During an observation on 7/16/25 at 10:29am, Resident #104 was alone, lying awake in his bed, fidgeting with his shirt.During an observation on 7/21/25 at 9:14am, Resident #104 was alone, lying asleep in his bed.During an observation on 7/21/25 at 12:08pm, Resident #104 was alone, lying awake in his bed, fidgeting with the tab of his incontinence brief and then began pulling on the edge of his bed sheet. In an interview on 7/21/25 at 12:09pm, Registered Nurse (RN) O reported Resident #104 frequently fidgeted with his brief, clothing, sheets, and had pulled his urinary catheter out on this date. RN O reported Resident #104 appeared restless frequently but could not tolerating being up in his wheelchair due to the wounds on his bottom. RN O reported Resident #104's health had prohibited him from being out of bed regularly for months. During an observation on 7/22/25 at 9:52am, Resident #104 was asleep in his bed. The light was on, and his room was quiet. In an interview on 7/22/25 at 9:54am, RN AA reported he had not seen activity staff provide 1:1 room visits to Resident #104. In an interview on 7/22/25 at 9:57am, Licensed Practical Nurse (LPN) HH reported Resident #104 could not tolerate getting out of bed regularly because doing so caused his wounds to worsen and he appeared to be in pain when he was in his wheelchair. LPN HH

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1234842Based on observation, interview and record review the facility failed to identify signs and symptoms of a stroke for 1 (Resident #112) of 3 residents reviewed for change of condition, resulting in an Immediate Jeopardy when Resident #112 did not receive timely medical intervention for a stroke on 7/15/25 who then suffered significant loss of function of her left upper extremity, developing unilateral spatial neglect (condition where a person has difficulty noticing or responding to stimuli on one side of their body), facial droop, and decreased ability to communicate verbally.Findings include:The facility failed to accurately assess Resident #112 for a change in condition on 7/15/25 at 12:00pm when Physical Therapist (PT) JJ reported to Director of Nursing (DON) B that the resident exhibited new onset of left sided weakness, exceptional fatigue and a significant decline in the ability to self-transfer.The Immediate Jeopardy began on 7/15/25 when the facility failed to assess Resident #112 for a change in neurological status despite multiple reports of stroke like symptoms resulting in Resident #112 suffering significant loss of function of her left upper extremity, developing unilateral spatial neglect (condition where a person has difficulty noticing or responding to stimuli on one side of their body), facial droop, and decreased ability to communicate verbally. The Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on 7/17/25 at 12:02pm. The surveyor confirmed by interview, and record review that the Immediate Jeopardy was removed on 7/17/25, but noncompliance remains at a scope of isolated and severity of harm due to sustained compliance has not been verified by the State Agency. Review of Treatment and Intervention for Stroke, www.cdc.gove/stroke/treament/index.html, revealed If you get to the hospital within 3 hours of the first symptoms of an ischemic stroke, you may get a type of medicine called a thrombolytic (a clot-busting drug) to break up blood clots. Tissue plasminogen activator (tPA) is thrombolytic. tPA improves the chances of recovering from a stroke. Studies show that patients with ischemic strokes who receive tPA are more likely to recover fully or have less disability than patients who do not receive the drug.Review of Impact of Time to Treatment on Endovascular Thrombectomy Outcomes in the Early Versus Late Treatment Time Windows, published 2023, https://www.ahajournals.org/doi/10/1161/STROKEAHA.122.040352, revealed The impact of time to treatment on outcomes of endovascular thrombectomy (EVT)(mechanical removal of clot in a blocked blood vessel) especially in patients presenting after 6 hours from symptom onset is not well characterized. increased time from symptom onset to treatment is significantly associated with lower change of independent ambulation and ability to be discharged home.Review of an admission Record revealed Resident #112 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: encounter for surgical aftercare following surgery on the circulatory system, aortic stenosis (narrowing of the valve in the large blood vessel branching off the heart), hyperlipidemia (high cholesterol), history of venous thrombosis (blood clot in a vein) and embolism (blood clot that has broken off and traveled into the blood stream), diabetes mellitus type 2 (condition in which the body cannot use insulin properly to regulate blood sugar levels), and morbid obesity.Review of a Minimum Data Set (MDS) assessment for Resident #112 with a reference date of 7/4/25, revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #112 was mildly cognitively impaired. Section B of the MDS revealed Resident #112 could always make herself understood with verbal expression. Section GG revealed Resident #112 required supervision for rolling side to side in bed.Review of a Care Plan for Resident # 112 with a reference date of 4/2/25, revealed a focus/goal/interventions of: Focus: (Resident #112) is at risk for cardiac complications r/t (related to)multiple cardiovascular diseases: hyperlipidemia, cardiac murmur, recent subaortic membrane resection (open heart surgery), aortic stenosis.Goal: Will be free from s/sx (signs and symptoms) of cardiac complications. Interventions:.observe/document/report to physician PRN (as needed) any s/sx of cardiac distress:.shortness of breath.In an interview on 7/16/25 at 2:31pm, PT JJ reported she conducted a therapy discharge assessment on Resident #112 on 7/15/25. PT JJ reported she had not previously provided therapy to the resident but had reviewed her therapy notes and was told by therapists who knew her well that Resident #112 was nearly independent with most tasks prior to her session on 7/15/25. PT JJ reported she recognized right away that Resident #112 appeared to be struggling with tasks that she had not needed assistance with during her prior therapy session. PT JJ reported Resident #112 did not have functional use of her left arm during the session, appeared exceptionally fatigued and was difficult to understand. PT JJ reported she went to DON B (who was caring for the resident that day) and inquired if Resident #112 had a history of having

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2563197. Based on observation, interview, and record review, the facility to ensure safety and prevent a major injury 1 of 3 residents (R108) reviewed for safety, resulting in an Immediate Jeopardy when, on 7/2/25 at 5:04AM, R108 fell from a transferring position onto an exposed metal bracket at the end of her bed impaling her in the soft tissue of her left buttock entering the rectum cutting it and the anal sphincter and also suffering an open fracture of the pubis ramus. The injured tissues required surgical reconstruction and after complications, placement of an ostomy (surgery that creates a new opening in your body for waste to come out).Findings include:The Facility failed to identify environmental hazards and risks of an exposed bed frame bracket. On 7/2/25 at 5:40 AM, R108, who was a fall risk with two or more previous falls, was found impaled on the exposed bracket of her bed. The facility determined at the time of R108's fall on 7/2/25, there were eight additional resident beds that did not have the foot boards installed. An interview with Plant Maintenance (PM) M revealed the 8 beds did not have foot boards installed when they arrived and that only the bottom bracket where it attached was left on the bed. The Nursing Home Administrator (NHA) A reported not knowing how long the beds had been in use with the exposed bracket in place but added they have been in place longer than I've worked here.The Nursing Home Administrator (NHA) A was notified on 7/15/25 at 2:25 PM of the Immediate Jeopardy on 7/2/25 at 5:40 AM when R108 was found impaled on the exposed bracket of her bed after a fall. The surveyors confirmed by observation, interview, and record review, that the Immediate Jeopardy was removed on 7/2/25 but noncompliance remained at scope of isolated and severity of actual harm due to maintenance not fully trained in bed maintenance and safety and sustained compliance had not been verified by the state agency. According to the Minimum Data Set (MDS) dated [DATE], R108 scored 9/15 (moderately cognitively impaired) on her BIMS (Brief Interview Mental Status). R108 was occasionally incontinent and had diagnoses that included right artificial knee joint, cognitive communication deficit, and a history of falling. Section J-Fall History on Admission/Entry or Reentry, indicated R108 had two or more falls since admission or prior assessment with no injury. Section GG-Functional Abilities and Goals indicated a wheelchair was used for mobility.Review of R108's Emergency Medical Service (EMS) Run-Sheet dated 7/2/25 revealed, .Dispatch Reason.penetrating trauma.impalement. musculoskeletal/skin.back.trauma injury.fall.sacral-midline.puncture/stab wound.patient was attempting to get out of bed despite being wheelchair bound, when she fell on the L-shaped corner piece of her metal bed frame.On EMS arrival patient was laying on her right side, staff members had lifted her off the metal piece and laid her on the floor. There was a large, coagulated pool of blood.the post had held her up off the floor. Review of R108's 5th District EMS Field Notes dated 7/2/25 reported the resident was impaled by metal bed frame approximately 3-4 inches.Review of R108's Trauma/Surgical Critical Care History and Physical dated 7/2/25 revealed, .brought in as a Tier I Trauma.suffering a mechanical ground-level fall with her left buttock landing onto her metallic bed frame.3 to 4 inches of the exposed bed frame had entered the patient's soft tissue of her left buttock.noted to be fair amount of exsanguination and blood loss.some form of injury to her anal canal or rectum.complaining of left gluteal and buttock pain.Physical Assessment.anorectal 4 cm radial laceration outside the anoderm in the left lateral position with extruding subcutaneous fat and blood.there is a comminuted fracture of the left inferior pubic ramus and ischial tuberosity with surrounding subcutaneous gas. soft tissue hematoma in the left buttock/perineal region.warrant further exploration and endoscopy.admit. Operating today for rectal exam under anesthesia, flexible sigmoidoscopy, possible exploratory laparotomy, possible bowel resection.Review of Investigation authored and provided by NHA A on 7/2/25 reported at approximately 5:40 AM, a nurse was in the hallway near the resident's room and heard a noise. Upon entrance to the room, the nurse noticed the resident had a fall at the end of her bed. The resident was sent to the ER for further evaluation. Once evaluated in the ER, the facility learned that (R108) had a fracture to her left inferior pubic ramus. It was noted the Investigation did not mention the penetrating trauma/impalement of a metal bracket to the resident's buttock that caused bleeding.Review of R108's Care Plan revealed:-10/15/2025, focused on Risk for Decline in Cognition and had impaired cognitive function or impaired thought processes related to and including dementia and cognitive communication deficit. The goal for the resident included having her needs met daily using interventions that included anticipate and meet needs as needed and anticipating needs from non-verbal indicators and past preferences as known. -10/3/2024, focused on Risk for Fall related injury and falls related to history of falls, decreased mobility

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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. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 123442Based on interview and record review, the facility failed to assess and monitor resident nutritional status in 1 of 3 residents (Resident #105) reviewed for notifications, resulting in a 12% weight loss for Resident #105.Findings include:Resident #105Review of an admission Record revealed Resident #105 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: encounter for surgical repair aftercare following surgery on the nervous system, dysphagia (difficulty swallowing) and weakness.Review of a Minimum Data Set (MDS) assessment for Resident #105 with a reference date of 5/3/25, revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #105 was mildly cognitively impaired. Section K revealed Resident weighed 191 pounds at the time of admission and was on a mechanically altered diet. Section L indicated the resident experienced mouth or facial pain, discomfort or difficulty with chewing. Review of a Care Plan for Resident # 105 with a reference date of 4/26/25, revealed a focus/goal/interventions of: (Resident #105) is at nutritional and/or dehydration risk R/T (related to): medical dx (diagnoses) including intracranial abscess and granuloma (area of infection and localized cluster of immune cells with the skull).mechanically altered texture(diet); refused mech(mechanical) soft, preferred pureed texture.at risk for malnutrition. Goal: Will not have unplanned significant weight change =/-5% x 30d (days).Interventions: .Notify RD (Registered Dietitian), family and MD (Doctor of Medicine) of significant weight changes.Observe and evaluate weight and weight changes.Review of an Infectious Disease Progress Note hospital record for Resident #105, with a reference date of 4/21/25 revealed Clinical Weight: 93.5kg (kilograms) (206 pounds).Review of a Nutritional Risk Screening Assessment for Resident #105 with a reference date of 4/29/25 revealed 1. A. Most Recent Weight 191.2 date: 4/26/25. 2. Screening: A. Moderate decrease in food intake.D. has suffered psychological stress or acute disease.F. Body Mass Index (BMI)=BMI 23 or greater.Score: 9. Category: At Risk of Malnutrition.In an interview on 7/12/25 at 12:17pm, Family Member (FM) W reported Resident #105 lost a significant amount of weight during his stay at the facility. FM W reported she frequently asked staff how much Resident #105 had eaten and was worried he was not receiving enough assistance at mealtime. FM W reports she voiced her concern about Resident 105's weight loss but nothing was done.Review of a Weight Summary Report for Resident #105 revealed the resident weighed 191.2#'s on 4/26/25, 168.9#'s on 5/7/25, and 168.9# on 5/12/25. Resident #105 lost 22.3 pounds/12% of his total body weight in 11 days.In an interview on 7/21/25, at 10:17am, RD OO reported per facility policy, she and the physician should be notified when a resident experiences a weight loss greater than 5% of their body weight. RD OO reported she was not notified of Resident #105's 12% weight loss. RD OO reported it was important that both she and physician receive prompt notification if a resident loses a significant amount of weight (greater than 5%) because that would warrant further medical evaluation to determine underlying causes, need for new diet orders, and need for the addition of supplements to support nutritional needs. RD OO reported Resident #105 was healing from a major surgery and studies had shown that optimizing a resident's nutrition correlated with better outcomes following major medical issues. When further queried about the lack of RD/physician notification of Resident #105's significant weight loss, RD OO reported she relied on nursing management and the Certified Dietary Manager to oversee monitoring of each resident's weight, but the facility had a change in staff and Resident #105's weight loss may have been overlooked.In an interview on 7/21/25 at 2:37pm, Director of Nursing (DON) B reported it was the nursing staff's responsibility to communicate a resident's weight loss to the RD and to the physician. DON B confirmed that based on the documented weights, Resident #105 had a 22-pound weight loss, and there was no documentation that the RD or the physician had been notified. Review of Physician Notes for Resident #105 from 4/26-5/8/25 revealed no acknowledgement of the resident experiencing a significant weight loss or further evaluation of nutritional needs.Review of a Weight Management policy with a reference date of 9/22/23 revealed Policy: Residents will be monitored for significant weight changes.any resident with unintended weigh loss will be evaluated by the interdisciplinary team (IDT).Dietary Manager, Unit Manager and /or the RD are to communicate weight changes to the IDT, attending physician.

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	235264	A. Building B. Wing	07/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #1234844 and #1234842Based on observation, interview and record review the facility failed to ensure facility staff documented resident care in the medical records for 2 residents (Resident #104 and Resident #105) reviewed for records, resulting in the potential for worsening of health conditions in incontinuity of care. Findings include:Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: stroke (damage to the brain from interruption of its blood supply), and pressure injury to heels, sacral region(bottom).Review of a Minimum Data Set (MDS) assessment for Resident #104 with a reference date of 3/1/25 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated Resident #104 was not able to complete the interview. Section GG revealed Resident #104 was dependent for bed mobility and transferring from bed to wheelchair. Section H revealed Resident #104 had an indwelling urinary catheter in place. Section M revealed Resident #104 had one or more unhealed pressure ulcers. Review of a Care Plan for Resident # 104 with a reference date of 1/19/25, revealed a focus/goal/interventions of: 1. (Resident #104) unable to tolerate nutritionally adequate food.requiring the use of feeding tube.Goal: Will be free from aspiration. Intervention: Provide care to (Resident #104's) tube site as ordered. 2. (Resident #104) is at risk for urinary tract infection. Goal: will show no s/sx (signs and symptoms) of urinary tract infection. Interventions: provide catheter care per policy. 3. (Resident #104) has actual impairment to skin.Goal: Will have no complications related to deep tissue injury. Interventions .treatment to skin impairment per order.Review of a Treatment Administration Record for Resident #104 with a reference date of July, 2025 revealed 1. Physician Order: Cleanse Peg Tube site with wound cleanser and apply dry dressing every evening shift, start date 6/26/25. This treatment was not documented on 7/2/25 and 7/19/25. 2. Wound Care: Right heel, betadine soak, abd (abdominal) pad and wrap with kerlix, everyday shift for wound care, start date 6/29/25. This treatment was not documented on 7/16/15 and 7/19/25. 3. Apply skin prep to red area on right medial foot Q (every) shift until resolved, start date 7/11/25. This treatment was not documented on either shift on 7/16/25 and 7/19/25. 4. Dakins (1/2 strength) External solution, Apply to wounds topically every shift, start date 6/25/25. This treatment was not documented on the night shift for 7/2/25, day shift for 7/16/25, day or evening shift on 7/19/25. 5. Foly catheter care with soap and water, start date of 6/26/25. This care was not documented on the night shift of 7/2/25, the day shift of 7/16/25, the day or evening shift of 7/19/25. 6. Wounds: bilateral Buttock: Irrigate wound with saline, apply triad creme to surrounding skin, pack with Daki's Dampened Kerlix gauze every shift, start date 6/29/25. This treatment was not documented on the night shift on 7/2/25, the day shift on 7/16/25, the day or night shift on 7/19/25. Resident #105Review of an admission Record revealed Resident #105 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: encounter for surgical repair aftercare following surgery on the nervous system, dysphagia (difficulty swallowing) and weakness.Review of a Minimum Data Set (MDS) assessment for Resident #105 with a reference date of 5/3/25, revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #105 was mildly cognitively impaired. Section K revealed Resident weighed 191 pounds at the time of admission and was on a mechanically altered diet. Section L indicated the resident experienced mouth or facial pain, discomfort or difficulty with chewing.Review of a Care Plan for Resident # 105 with a reference date of 4/26/25, revealed a focus/goal/interventions of: 1. (Resident #105) is at nutritional and/or dehydration risk R/T (related to): medical dx (diagnoses) including intracranial abscess and granuloma (area of infection and localized cluster of immune cells with the skull).mechanically altered texture(diet); refused mech(mechanical) soft, preferred pureed texture.at risk for malnutrition. Goal: Will not have unplanned significant weight change =/-5% x 30d (days).Interventions: .Notify RD (Registered Dietitian), family and MD (Doctor of Medicine) of significant weight changes.Observe and evaluate weight and weight changes.2. Focus: (Resident #105) is at risk for urinary tract infection and catheter related trauma. Goal: Catheter will remain.without complications. Interventions: Observe/record/report to physician s/sx (signs and symptoms) of UTI (urinary tract infection) .Review of a Treatment Administration Record for Resident #105 with a reference date of May, 2025 revealed Physician's Orders: 1. Incentive Spirometry, every shift for immobility-reduced physical function for 14 days, start date 4/27/25. Training and use of the incentive spirometer was not documented on the night shift on 5/6/25. 2. Apply skin prep to intact blister once daily, location right heel, everyday shift for wound. Start date 5/3/25. This treatment was not documented on

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. This citation pertains to intakes 1234839, 1234837, 2563197, 2564473, 1234842, and #1234844 Based on interview and record review, the facility failed to identify quality deficiencies and issues that should have been addressed in quality assurance committee, resulting in systems failure of ensuring resident treatments were completed and documented per physician's orders, change of condition was identified and assessed in a timely manner, facility beds were properly assembled and maintained in safe working condition, infection control practices were implemented, activities were provided to meet each resident's needs, and the facility provided an environment that was free from abuse. This deficient practice has the potential to affect all 89 residents. Findings include:Review of a Quality Assurance Performance Improvement Committee policy with a reference date of 3/5/25 revealed Quality Assurance and Performance Improvement (QAPI)- a coordinated application.takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality.The QAPI committee meets quarterly or, more often as necessary .the committee consists of the Director of Nursing, The Medical Director, at least three other staff, at least one of who must be the administrator. Review of an Abuse Prohibition Policy with a reference date of 9/9/22 revealed The facility QAPI Committee will investigate occurrences, patterns, and trends that may indicate the presence of abuse, neglect, or misappropriation of resident property to determine the direction of the investigation/intervention, through analysis of systems, audits, and reports. Review of QAPI Committee Sign in Sheets revealed the committee met on 1/20/25, of note the sign in sheet did not reflect attendance by the Infection Preventionist, on 2/24/25 with only 3 staff in attendance (Infection Preventionist not present), 3/28/25 when the Administrator and Director of Nursing not present, and 4/25/25.In an interview on 7/22/25 at 1:20pm, Nursing Home Administrator (NHA) A reported the QAPI committee had determined they needed to meet monthly but the committee but had not met since 4/25/25. When further queried, NHA A reported the QAPI committee had missed a few meetings and had not been successful coordinating attendance of the Medical Director as required. NHA A reported the QAPI Committee had not collected or analyzed data related to identification and assessment of resident change of condition, safety/maintenance of beds, recent situations of resident abuse. NHA A reported staff communication had been identified as a cause of one situation of resident-to-resident abuse, but no steps had been taken toward improvement. NHA A confirmed the facility was not tracking compliance with the physician being notified of resident change of condition or care being provided as ordered by the physician. NHA A confirmed that without a comprehensive QAPI program, the facility could not ensure areas for improvement were quickly identified and corrected.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standards of infection control practices for one (R112) of one resident reviewed for the use PPE (Personal Protection Equipment) for Enhanced Barrier Precautions (EBP), resulting in the potential of cross-contamination and harborage of bacteria to a vulnerable population. Findings include:According to the Minimum Data Set (MDS) dated [DATE], R112 scored 12/15 (cognitively intact) on her BIMS (Brief Interview Mental Status), required substantial/maximal assistance for toileting needs, used a wheelchair for mobility, and surgical aftercare for cardiovascular system. Review of R112's Order Summary revealed:-7/1/25 Enhanced Barrier Precautions while performing high-contact care activities including changing bed linens.-7/2/25 Monitor surgical incision to sternum.-7/3/25 32 staples to midline sternum. Review of R112's Care Plan dated 7/11/25, indicated a potential for complications from surgical wounds. Surgical incision midline chest s/p subaortic membrane resections. The goal was for the surgical wound to heal without signs of infection. Interventions to meet the goal included observing signs of infection. It was noted there was no focus for Enhanced Barrier Precautions. During an observation and interview on 7/16/25 at 9:30 AM, R112's door had an Enhanced Barrier Precautions sign announcing bed-1 (R112 bed area) required the use of PPE, including a gown, while providing direct cares. Upon entering the room, R112 was sitting on the toilet with Certified Nursing Assistant (CNA) K provided personal direct cares. CNA K was wearing disposable gloves but no other PPE. CNA K stated, I don't think (R112) is on Enhanced Barrier Precautions. The CNA continued to assist R112 with personal hygiene cares. During an interview on 7/16/25 at 4:05 PM, CNA K stated, Gowns and gloves are to be worn with Enhanced Barrier Precautions and doing direct care. When residents tell you it's an emergency they must go to the bathroom, what are you supposed to do? I did not wear a gown when caring for (R112) this morning. During an interview on 7/21/25 at 12:12 PM, Wound Nurse/Registered Nurse DD stated, The facility follows CDC (Centers for Disease Control) guidelines including the use of PPE with residents that are on EBP. It is important to follow the guidelines to prevent disease transmission. All staff have been trained to look for the signage that designates what precautions some residents are on and also when and why to wear PPE. (CNA K) should have worn a gown while performing direct personal care while toileting (R112). (R112) just had open heart surgery and has a surgical wound.

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F 0909 Level of Harm - Actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2563197. Based on observation, interview and record review, the facility failed to perform routine inspections and maintenance to ensure safety of resident beds for 1 of 1 resident (R108) reviewed for bed safety, resulting in a life-altering injury for R108 and potential for further injury for 9 additional residents who had foot-board brackets on their beds with no foot board.Findings include: According to the Minimum Data Set (MDS) dated [DATE], R108 had a BIMS (Brief Interview Mental Status) of 9/15, indicating the resident was cognitively impaired. Diagnoses that included cognitive communication deficit and history of falling. Review of R108's Progress Note dated 7/2/25 5:40 AM, revealed, .a crash was heard.(R108) was observed lying on her right side with her left buttocks impaled on a bracket used to mount a footboard on the bed. The bracket had entered her butt checks and was pressing the lateral side of her buttocks out During an interview on 7/14/25 at 9:52 AM, with Nursing Home Administrator (NHA) A and Maintenance Director M, Maintenance M reported there were a total of 9 beds that had two metal brackets, approximately 4 with a pointed top that extended up from a 90-degree bend at the end of the bed to hold a footboard. There were no footboards to place in the brackets with the beds being in use from before he had taken over as Maintenance since May of 2025. NHA A reported she had no idea how long the beds had been in use with the exposed bracket in place but added they (metal brackets) have been in place on the beds with no footboards longer than I've worked here. During an interview on 7/15/25 at 9:42 AM, Registered Nurse (RN) N stated, (R18's) bed had metal brackets at the end of the bed that was sticking up. There was no footboard in them. One bracket had impaled (R108) into her left buttock. During an interview on 7/15/25 at 10:38 AM, RN Q stated, I work at the facility and (R108) is my family member. I saw (R108) on the morning of the incident. There were two metal brackets approximately 6 high at the end of the bed that were supposed to hold a footboard. There was no footboard in the brackets. Review of facility Closed Work Orders, dated 3/1/25-7/14/25 indicated not one of the nine beds with exposed metal brackets had been listed on the work order list.