STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235269	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellspring Lutheran Services	725 West Genesee Frankenmuth, MI 48734

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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 - Some	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 Code Status was accurately assessed, documented and accessible in the medical record and plan of care for 4 residents (#9, #27, #28, #45) , resulting in the potential for the resident's lack of informed knowledge related to options for code status and miscommunication of code status which could lead to a lack of appropriate interventions for care. Resident #27 (R27) A record review of the Face Sheet and Minimum Data Set/MDS assessment indicated R27 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Unspecified Dementia, severe with other behavioral disturbance, Delusional Disorders, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, and Obstructive and Reflux Uropathy in addition to other diagnoses. A review of R27's assessment for Code status preferences titled, Advance Care Planning Form, revealed No was checked for Cardiopulmonary Resuscitation (CPR). Yes was marked for Artificial Nutrition (tube feedings), Yes to Artificial Hydration (IV, Hypodermoclysis) and Diagnostic Testing (Lab, X-rays, Imaging), and Yes for Infection Control Outbreak Testing (Covid-19, Influenza Testing, etc.). R27 signed the document on [DATE]. A review of the electronic medical record for R27 identified DNR (Do not resuscitate) on the resident's Face sheet (main page). There was no mention of the specific choices the resident had chosen on the Advance Care Planning Form. On [DATE] at 4:00 PM, a review of the Medical Incapacity determination form entitled MEDICAL revealed R27 is unable to participate in decisions regarding medical or mental health treatment. Signed by R27's Primary Physician on [DATE] and a Licensed Physician/Psychologist on [DATE]. A review of the physician's DO-NOT-RESUSCITATE (DNR) orders for R27 identified the following: DNR: no directions specified, signed by R27 on [DATE]. There was no mention of the specific choices the resident had chosen on the Advance Care Planning Form. Section B. Resident Advocate (MDPOA) Consent was left blank. The DNR order form was not up to date with R27's current status. No signature by the Medical Durable Power of Attorney was obtained in R27's DNR Order Form. A review of the Care Plans for R27 revealed that there was no mention of R27's Code status (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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(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 - Some	preferences in the care. The Social Worker (SW H) was interviewed on [DATE] at 4:36 PM, and revealed: The SW H indicated that All DNR Status did not have a care plan in place because it does not say so in the policy. There is an MD (Physician) Order, and the DNR Form is uploaded in the chart. We do not Care Plan the DNR status. SW H stated that both the MD and the Psychologist deemed the resident medically and mentally incapacitated in [DATE]. When asked about the date the Psychologist had signed the form, the SW insisted it was July, although the date written was [DATE]. The SW H further stated it appears to be a 9 (referring to September), but that's how he writes a 7. SW H indicated she had reached out to the DPOA regarding the Activation of the DPOA and DNR Forms, but with no success. When asked if she had entered the notes reflecting those changes and attempts to reach the DPOA, she said yes. A review of the SW Notes on [DATE] at 3:00 PM (before the SW interview) revealed that there was no mention of DNR and obtaining a signature from the DPOA in the R27's record from June to [DATE] Progress Notes. The following day, on [DATE], the surveyor reviewed the progress notes and apparently noted that three (3) late entries were added in R27's progress notes. LATE ENTRY: was entered on [DATE] for [DATE] e-signed by the SW. LATE ENTRY: was entered on [DATE] for [DATE] e-signed by the SW. LATE ENTRY: was entered on [DATE], time 16:49 (4:49) for [DATE] e-signed by the SW These LATE ENTRY notes were compared to the previously reviewed progress notes and were entered after the SW interview was conducted on [DATE], after 4:30 PM. Policy The facility's Policy and Procedure of Advance Directive, revised on 02/2024, revealed: 1. Identity. Upon Admission, the facility will determine whether the resident has executed advance directives (e.g., a living will and/or Patient Advocate Designation). Each Resident DPOA will then complete the Advance Care Planning form. If the resident is unable to complete the Advance Care Planning Form, and has no activated DPOA, they will remain a full-code. 1b. DNR-Patient Advocate. The patient advocate may sign the DNR form for the resident as long as the Patient Advocate Designation grants them the authority to request DNR status. The same procedure applies for completing the DO-NOT RESUSCITATE ORDER form and obtaining a verbal order for the DNR status as above. 6. Determine Resident's Capacity. All individuals are presumed to have the capacity to make informed health care decisions unless the individual has been adjudicated as incompetent in a court of law or unless a determination is made by two physicians, the resident's attending physician and another physician or a licensed psychologist, that the individual does not have the capacity to make health (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care decisions. 8. Periodically Re-evaluate. The resident's code status will be reviewed with the resident and/or representative at least quarterly and documented in the medical record. In the event that the resident and/or representative did not attend the care conference, they will be contacted either by telephone or mail to review the resident's treatment choices. The resident may change treatment choices at any time. The resident's physician will be notified as appropriate, and the resident's plan of care will be revised accordingly. Advance Directives Resident #9 A record review of the Face Sheet and Minimum Data Set/MDS assessment indicated Resident #9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: history of a stroke, right sided weakness, schizophrenia, dementia, depression, and heart disease. The MDS assessment dated [DATE], revealed the resident had severe memory loss. Resident #9 was receiving Hospice services. A review of Resident #9's assessment for Code status preferences titled, Advance Care Planning Form, revealed No was checked for Cardiopulmonary Resuscitation and Artificial Nutrition (tube feedings) and Yes to Artificial Hydration (IV, Hypodermoclysis) and Diagnostic Testing (Lab, X-rays, Imaging). The document was signed by the resident's Guardian on [DATE]. A review of the electronic medical record identified DNR (Do not resuscitate) on the resident's Face sheet (main page). There was no mention of the specific choices the resident had chosen on the Advance Care Planning Form. A review of the physician orders for Resident #9 identified the following: DNR: no directions specified dated [DATE]. There was no mention of the specific choices the resident had chosen on the Advance Care Planning Form. A review of the Care Plans for Resident #9 revealed there was no mention of Resident #9's Code status preferences. Resident #28 A record review of the Face Sheet and Minimum Data Set/MDS assessment indicated Resident #28 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, anxiety, COPD, diabetes, depression, Bipolar disorder, hypothyroidism, heart disease, GERD and gout. A review of Resident #28's assessment for Code status preferences titled, Advance Care Planning Form, revealed No was checked for Cardiopulmonary Resuscitation and Artificial Nutrition (tube feedings) and Yes to Artificial Hydration (IV, Hypodermoclysis) and Diagnostic Testing (Lab, X-rays, Imaging). The document was signed by the resident's Guardian on [DATE]. The physician order for DNR was written prior to the Guardian signing the Advance Care Planning Form. A review of the electronic medical record for Resident #28 identified DNR (Do not resuscitate) on the resident's Face sheet (main page). There was no mention of the specific choices the resident had (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chosen on the Advance Care Planning Form. A review of the physician orders for Resident #28 identified the following: DNR: no directions specified dated [DATE]. There was no mention of the specific choices the resident had chosen on the Advance Care Planning Form. A review of the Care Plans for Resident #28 revealed there was no mention of Resident #28's Code status preferences. Resident #45 A record review of the Face Sheet and Minimum Data Set/MDS assessment indicated Resident #45 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Diabetes, End stage kidney disease, dependence on renal dialysis, depression, heart disease, anxiety, COPD, claustrophobia and history of a stroke. A review of Resident #45's assessment for Code status preferences titled, Advance Care Planning Form, revealed No was checked for Cardiopulmonary Resuscitation and Artificial Nutrition (tube feedings) and Yes to Artificial Hydration (IV, Hypodermoclysis) and Diagnostic Testing (Lab, X-rays, Imaging). The document was signed by Resident #45 on [DATE]. A review of the electronic medical record for Resident #45 identified DNR (Do not resuscitate) on the resident's Face sheet (main page). There was no mention of the specific choices the resident had chosen on the Advance Care Planning Form. A review of the physician orders for Resident #45 identified the following: DNR: no directions specified., dated [DATE]. There was no mention of the specific choices the resident had chosen on the Advance Care Planning Form. A review of the Care Plans for Resident #45 revealed there was no mention of Resident #45's Code status preferences. On [DATE] at 3:18 PM, Social Worker H was interviewed about the residents' Code Status. She said the nurse looked at the Code status form and obtained a physician's order for DNR. She said DNR was also placed on the resident's Face sheet in the electronic medical record. Reviewed with the Social Worker H that DNR did not identify each of the resident's specific wishes/choices. She said the nurse would need to look in the electronic chart at the assessment document. The Social Worker was asked how the staff would have time to do that during an emergency. The Social Worker said there was a binder at the desk, and they could look it up there, as she placed the information in the binder. The Social Worker was asked if the resident's specific information was identified in the resident's Care plans and she said it was not on the care plans.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication administration error rate of less than 5% when nine (9) medication errors were observed from a total of 25 opportunities for three residents (Resident #1, Resident #29 and Resident # 57) of five (5) residents observed for medication administration, resulting in an error rate of 36.0%. Findings Include: On 8/13/25 at 7:45 AM, Registered Nurse K was observed administering the medication at the [NAME] End Nurse's Station.RN 'K' gave R57 the Chewable Aspirin (ASA) tablet, which was placed with three other oral medications in one medicine cup. R# was observed taking all her medications whole at once and swallowing them after a small cup of water. Resident #57 (R57) A review of R57 Face Sheet revealed R57 was admitted at the facility on 8/9/ 25 with the following diagnoses: Osteoporosis, Venous insufficiency, and pathological Fracture in addition to other diagnoses.On 08/13/2025 at 7:45 AM, RN K was observed preparing R57's morning medication. The following medications were:Chewable Aspirin (ASA) MultivitaminsSpironolactone Vit. COral ASA Chewable tablet was mixed with other medications and taken orally without being separated, distinguishing it as a chewable tablet.The Metamucil powder was mixed with water and administered with the four (4) oral medications in a small medication cup. Resident #1(R1) R1, according to the facility face sheet, was [AGE] years old and admitted to the facility on [DATE] with the diagnosis of Chronic Systolic Congestive Heart Failure, Acute Respiratory Failure with Hypoxia, Lobar Pneumonia, Essential Hypertension, and History of Transient Ischemic Attack (TIA) and Cerebral Infarction, in addition to other diagnoses.A medication administration (Med Pass) observation was conducted on 08/13/2025 at 7:50 AM. RN K was observed administering eight oral medications and one inhaler puff to R1. The following eight (8) medications were due at 8:00 AM:Glimepiride (Amaryl) 2mg 1 tabHydrochlorothiazide (Hydrodiuril) 1tab 25 mglosartan tab (Cozaar) 100 mgNifedipine ER (Procardia) Tab 90 mgAspirin chew tab 81 mgCitalopram (Celexa) tab 40 mgClopidogrel (Plavix) 75 mgFerrous Sulfate FC tab 325 It was observed that the chewable Aspirin (ASA) was mixed and given along with the rest of the oral medication, placed in a single med cup. R1 took all eight (8) oral pills, including the Aspirin, and swallowed them all at once. The chewable Aspirin was not chewed as the doctor ordered. Resident #29 (R29) R29 was [AGE] years old initially admitted on [DATE] with the diagnosis of Type 2 Diabetes Mellitus with foot ulcer, Other Cerebral Infarction due to occlusion or stenosis of small artery, atherosclerotic heart disease of Native Coronary Artery Without Angina Pectoris, and Essential Hypertension in addition to other diagnoses. R29, during Medication Administration, was in the hallway of the [NAME] Wing Nursing Station when he asked if his meds would be given after his therapy so he wouldn't be tired during the therapy session. RN K said okay and went on to the following resident. The following seven (7) medications were held without notifying the Provider MD:R29 Bag 1 contained:Acidophilus Cap 500 mg (Probiotic) in addition to other diagnoses.Aspirin EC Tab 81 mg 1 tab (minor aches and pains)Carvedilol (Coreg)Tab 3.125 mg (Alpha and beta-blocker to treat serious heart and blood vessel conditions)Clopidogrel (Plavix) Tab 75 mg (antiplatelet conditions to prevent blood clot formation)R29 Bag 2 contained:Entresto Tab 24/26 mg (Use to treat chronic heart failure)Jardiance 1 tab (Type 2 diabetes treatment)Vitamin D3 Cap 5000U (1225 MCG) X 2 capsules (for bones and calcium absorption) On 8/13/25 at 10:45 AM. A follow-up with the RN K revealed that she had administered R29's pills at around 10:30 AM. She admitted it was a late med pass. RN K was asked if the doctor was informed about the late medication, and RN K said No. Later in the afternoon on 8/13/25 at 3:00 PM, RN K was asked if she had notified the doctor or had noted the late medication administration in R29's clinical record. She said, I did not have time to do that yet, but I will definitely inform the physician about the Resident's 8:00 AM medication.The nurse held seven (7) medications without a physician's notification of the delay. The nurse did not explain the consequences if the due medications are held to the resident (R29). R29's seven (7) oral medications (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were reviewed, including heart medications and blood thinners, scheduled at 8:00 AM. The surveyor was informed that all medications due at 8:00 AM were given by RN K at approximately 10:30 AM. The delay in medication observation was discussed with RN K, who administered medication late on 8/13/25 at 10:30 PM. The DON and Administrator were notified at 3:30 PM, thereafter, regarding the error.Upon data entry, the medication error was 36% over 25 observations. On 8/14/25 at 9:20 AM, policies were asked regarding medication administration and the PICC line care policy, which is to administer Antibiotics and flush after . In addition to a 36% Medication Error that was established on 8/13/25 at 10:30 AM, another late medication administration incident was observed in the [NAME] Wing Nursing Station the following morning on 8/14/25 at 10:30 AM. On 08/14/2025 at 10:23 AM, Nurse L, The Medcart's computer screen had a lot of reds colored boxes. When Nurse L was asked what the red shaded boxes mean, she revealed that It means the medication is 'overdue. Nurse L explained that R58's medication was not available from the Pharmacy and that she was running behind with passing R58's 8:00 AM medications. Nurse L furthermore stated, We have 22 Residents with just one nurse administering all their meds due to. Resident #58 (R58) According to a Review of R58 Face Sheet, R58 was admitted from a nearby hospital to the facility on 8/11/25, with the following diagnoses: Acute Renal Failure, Urinary Tract Infection (UTI), Metabolic Encephalopathy, Paroxysmal Atrial Fibrillation, Essential Hypertension, Gastro-esophageal Reflux Disease (GERD), and Atherosclerotic Heart Disease in addition to other diagnoses.Seven (7) medications were shown in red on the computer screen, which said they were due by 8:00 AM, but were administered at 10:23 AM on 8/14/25. Nurse L denied calling the doctor for the late administration of R58, scheduled morning medication.Upon review of R58's list of noted medications, the following significant medications were delayed:Eliquis (Apixaban)Oral Tablet 2.5 mg was ordered to be given one tablet twice daily. Eliquis is an anticoagulant (blood thinner) used to prevent and treat dangerous blood clots.Coreg (Carvedilol)Oral Tablet 3.125 mg was ordered, one tablet twice daily. Coreg is an Alpha and Beta-blocker used to treat serious heart and blood vessel conditions. The facility's policies for Medication Pass Guidelines and Medication Error were requested and reviewed. Medication Pass Guidelines with a revised date of September 2023 indicated the following:Purpose:To assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each Resident by providing the administration of drugs in an accurate, safe, timely, and sanitary manner, and to systematically distribute medications to residents in accordance with state and federal guidelines.Physician's Orders: Medications are administered in accordance with orders of the attending physician.Procedure:.5. Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. The Policy for Medication Errors, with the release date of February 2023, was reviewed on 8/14/25 at 3:30 PM. It indicated,Policy:It is the policy of this facility to provide protections for the health, welfare, and rights of each Resident by ensuring residents receive care and services safely in an environment free of significant medication errors.Policy Explanation and Compliance Guidelines:The facility shall ensure that medications will be administered as follows:According to the physician's orders.Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines:Resident's condition.Drug category.Frequency of Error: If an error is occurring repeatedly, such as an omission of a resident's medication several times.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store and handle medications in accordance with acceptable pharmaceutical standards of practice and ensure medication refrigerator temperatures outside of acceptable parameters were addressed, resulting in the potential for contamination of medications, a lack of therapeutic benefits necessary to promote healing for residents, increased potential for adverse effects. Findings include:On 8/14/25, starting at 8:20 AM, two medication carts were checked and observed, and the narcotics were reconciled. Two medication rooms were inspected, which included the refrigerator that holds the medication requiring refrigeration per the manufacturer's recommendation, such as reconstituted IV solution, insulin, vaccinations, and suppositories.During Medication Storage inspection, Nurse L on 8/14/25 10:45 AM opened the refrigerator in the [NAME] Wing Medication Room, and the inside thermometer read 50 degrees Fahrenheit. Although Nurse L argued that it was 48 degrees a second ago, she reread and agreed it held at 50 degrees. When Nurse L was asked what temperature the refrigerator in the med room should be maintained at? Nurse L replied, 48 degrees. The refrigerator appeared to have been thawing with obvious water accumulation on the bottom drawer from the condensation. The contents of the refrigerator were as follows: Two (2) large plastic bags containing a total of 9 (Meropenem) Intravenous (IV) Solution Reconstitution 2GM antibiotic bulbs. Staff counted nine (9) bulbs specially prepared for a resident needing antibiotics bolus infusion through an IV Peripherally Inserted Central Catheter (PICC) Line. Other medications found in the refrigerator were: insulin (Lantus, Lispro & Humalog) pens assigned to various residents in the [NAME] Wing, Engerix-B vaccine, and packs of suppositories labeled as Bisacodyl and Acetaminophen.The bottom drawer holding the insulin pens and suppositories had water in the drawer bin. The base of the refrigerator was wet, and the floor had a water leak. The two (2) boxes of suppositories were soaked in clear fluid. According to the Centers for Disease Control and Prevention CDC (August 10.2024) https://www.cdc.govEngerix-B storage guidelines:Approved use: The Engerix-B vaccine is used to prevent hepatitis B in both children and adults.Storage Temperature: The vaccine must be stored in a refrigerator that maintains temperatures between 36 degrees Fahrenheit (2 degrees Celsius and 8 degrees Celsius.Handling: You should not freeze the vaccine or expose it to freezing temperatures, as this can destroy its potency.Monitoring: The Centers for Disease Control and Prevention (CDC) recommends continuous temperature monitoring using a digital data logger (DDL).If out of range: If the temperature falls outside the recommended range, the vaccine should be marked Do Not Use and isolated from other vaccines until further guidance from the manufacturer or health department is received.Temperature: Refrigerator Temp. Store between 2 degrees Celsius and 8 degrees Celsius, 36 degrees Fahrenheit and 46 degrees Fahrenheit.Monitoring refrigerator temperature for vaccines is critical to ensure their safety and effectiveness .The Director of Nursing was made aware on 8/14/25 at 10:40 AM and stated, there were no reports of temperature not within range received. All contents will be thrown out. We don't know how long the refrigerator was down. On 8/14/2025 at 10:46 AM, the Maintenance Director was in the Med Storage room and stated, The refrigerator broke. It does not work. He did not receive any complaint or report regarding the refrigerator all day. He assured the surveyor that the fridge would be replaced.Facility Policy was reviewed, entitled: Medication Room Refrigerators Policy (Revision Date: August 2023)Policy: It is the Policy of (Facility Name) to comply with the CDC recommendation for the storage of medications. Medications will be stored in an appropriate refrigerator. Refrigerators in each medication room will have a temperature reading and be recorded twice daily. Temperature will be maintained at 36 to 46 degrees.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the appropriate backflow prevention was installed on cross connections. This deficient practice increases the likelihood of contamination of the water supply due to a backflow event, potentially affecting all residents, staff, and visitors who consume water at the facility. Findings include: On 08/12/2025 at approximately 9:30AM observed a hose with an attached spray nozzle connected to the water line downstream of an atmospheric vacuum breaker (AVB) located in the kitchen near the dishwasher. On 08/12/2025 at approximately 1:30PM during the environmental tour of the facility, an interview was conducted with the Director of Maintenance I on the cross connection related to the attached spray nozzle in the kitchen. The Director of Maintenance I was knowledgeable about the cross connection and removed the hose with the attached spray nozzle. On 08/12/2025 at approximately 1:45 PM observed chemical feed dispenser supplied by the utility sink with an atmospheric vacuum breaker without an attached wasting tee, located in the janitor's closet in the basement, [NAME] hallway, and Morning [NAME] hallway. When interviewed about the cross connection, the Director of Maintenance I was unfamiliar with wasting [NAME] (or bleeder device). According to the 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve). According to the 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure choices on meals are honored and prompt response to call lights for Resident #6 (R6), maintain the resident's confidentiality of an emergency plan for Resident #49 (R49) and provide resident's privacy during medication administration for Resident #29 (R29) for three residents (R6, R49 and R29) of three reviewed for dignity. Findings include:Resident #49 (R49):A review of the Electronic Medical Record (EMR) conducted on August 12, 2025, at 3:00 PM revealed that R49 was admitted to the facility on [DATE]. She is currently under hospice care. Her Brief Interview of Mental Status (BIMS) Score dated July 2, 2025, was undetermined. The score box was left blank. However, staff indicated in the assessment that R49 had a memory problem (both short-term and long-term memory), a problem with recalling (names, faces, seasons, and locations), and her cognitive skills for daily decision making, according to the facility, were severely impaired. Her Minimum Data Set Assessment Section GG (dated July 2, 2025) revealed that R49 is dependent on staff for eating, oral hygiene, toileting, showering and bathing, dressing, and personal hygiene.According to the facility's RightsADLOn 08/12/2025 at 10:14 AM, R49's ADLs were being done in another resident's room. R49 was observed coming out of Rm112. R49 was greeted and was addressed by the name of the person residing in room [ROOM NUMBER]. The Certified Nurse Aide (CNA M), who was pushing R49 out of the room, corrected the surveyor and explained that the resident was not the person belonging to room [ROOM NUMBER]. CNA M explained that she used room [ROOM NUMBER] to cleaned and washed R49, who resides next door (Room # 114) CNA furthermore stated that she has been using room [ROOM NUMBER] to provide ADL Care for R49 because R49's roommate does not want R49's ADLs done in the room (#114), so she does it next door in room [ROOM NUMBER] since the resident in room [ROOM NUMBER] is out in the hall. When the surveyor asked, CNA M did not know if it was acceptable to use another resident's room to wash up another resident and complete their ADL task for another resident who belonged to a different room.On 8/12/2025 at 10:15 AM, an attempt to interview R49 revealed that although R49 was alert, she was not able to answer the surveyor's questions.An interview with Certified Nurse Aide (CNA) M was conducted on 8/12/25 at 10:15 AM. CNA M came out of the room, pushing R49, and stated that the resident who lived in room [ROOM NUMBER] was not in the room. They explained that R49's room is next door, but R49 had decided to use another resident's room. CNA was unsure whether she could use another resident's room to wash up another resident. She did not understand the reason why or why not. CNA# explained that she used another room for R49's ADL because R49's roommate does not want us to clean her up in her room. If you have met her roommate, you will know why.Advanced DirectivesUpon entering R49's room on 8/12/24 at 10:15 AM, R49's Emergency Plan was posted on the wall of her room right next to her bed for everyone to see. R49's name was handwritten with a black Sharpie pen, and the contents of the posted Emergency Plan specified:The Patient Name,The patient is currently receiving hospice care. Please call the Hospice Nurse for changes in patient status and comfort levels.In Bold Letters and All Caps- DO NOT CALL 911Following line written: Do NOT Resuscitate. R49's Nurse N was interviewed on 8/12/25 at 11:30 AM, Nurse N validated that the emergency plan was posted on the wall. Nure N stated she did not see anywhere else except for R49's room and did not know the reason behind whether it was her Advanced Directive status or because she was receiving hospice care.According to R49's roommate on 8/12/25 at 10:21 AM, she denied issues with the staff doing her roommate's (R49) ADLs in the room. Although she was bothered by the posted note taped on the wall that says Emergency Plan Do Not Call 911. Because it was R49's roommate's birthday recently, a lot of visitors came and were asking about the note on the wall. R49's roommate felt R49's privacy was violated and had stated that she does not want that paper posted on her wall. The roommate indicated that her own family was concerned and asked (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about the note when someone sees it.Upon review of the form on 8/12/25 at 10:30 AM, the form is from the facility hospice care agency notifying staff of her advanced directive status.The Social Worker (SW O) on 8/13/25 at 4:40 PM and the surveyor visited R49's room and noticed that the form was removed from the wall. Entering R49's room, the roommate stated that the form had come off this morning. R49's roommate was excited and said, Hallelujah! and was glad that it was no longer there. The SW O validated on 8/13/25 at 4:45 PM, that the form needed to come off the wall and did not need to be posted either.The Administrator, on August 13, 2025, at 4:45 PM, during an interview, revealed that the facility owns the hospice. However, the sheet was left there, and we instructed the hospice not to place it there for privacy reasons. Despite this, hers remained. Resident #6 (R6):R6 was admitted to the facility on [DATE] with a diagnosis of Congestive Heart Failure (CHF), Essential Hypertension, Chronic Pulmonary Edema, and General Anxiety Disorders in addition to other diagnoses. The Minimum Data Set (MDS) assessment for R6, dated July 18, 2025, revealed a Brief Interview of Mental Status Score of 15/15. A score of 15 means that R6 is cognitively intact. R6 Kardex as of 8/14/25 indicated that she is incontinent with bowel and bladder with a plan of care of checking upon rising, before meals, and at HS (bedtime) and as required for incontinence. Wash, rinse, and dry the perineum. Change clothing PRN (as needed) after incontinence episodes. It also revealed that R6 wears an incontinence brief. And was care planned to wash, rinse, and dry the perineum. Apply barrier cream.Call lightOn August 12, 2025, at 11:02 AM, an interview with R6 was conducted. R6 stated that just this past week, she waited for an hour for someone to answer her call light. When asked what happened next, she said that if you waited an hour long, what do you think would happen? I had an accident. Eventually, they cleaned me up. It doesn't happen most of the time. But that night it happened a couple of times. It's mostly during the night. I have some redness on my bottom. The aides put a sab and powder. I reported it, but I'm not sure if the staff member is still employed here. Every night we get somebody new.ChoicesWhen asked about choices, R6 said that food is a concern. There have been lots of substitutes lately, or they've run out of ideas. They let you pick some food choices, but they don't follow what you circled (pre-selected). I'm not sure why. Instead, they offer an alternate, and they are not bad. Sometimes I get a hot dog for supper or grilled cheese. They don't follow what you have picked from the menu. I just then eat what is there. Resident #29 (R29):During Medication Administration observation conducted on 8/12/25 at 8:30 AM, R29 was observed receiving his Lantus injection on his left deltoid given by the RN while he was at the [NAME] Avenue dining room with other residents waiting for their breakfast tray. A few minutes before this observation, at around 815 AM on 8/13/25, the nurse unhooked the empty antibiotic bulb from the PICC (Peripherally Inserted Central Catheter) Line after antibiotic infusion was completed and flushed in the hallway. Nurse K did not wash or sanitize her hands and did not wear gloves. Wiped the end cap of the PICC line with alcohol wipes with bare hands. R29 also received a nasal spray administered through both his nostrils in the hallway after his PICC Line antibiotic was unhooked. Nurse K did not wear gloves either when administering the nasal spray.According to R29 EMR reviewed on 8/13/25 at 12:00 PM, it revealed that R29 was admitted to the facility on [DATE]. He was [AGE] years old, admitted with a diagnosis of Type 2 diabetes Mellitus with Foot Ulcer, Non-Pressure chronic Ulcer of the Left Heel and Midfoot with unspecified severity, and osteomyelitis of the left foot and ankle, in addition to other diagnoses. R29 was prescribed the following: Lantus Solostart Subcutaneous Solution Pen-Injector 100 Unit/ML (Insulin Glargine) 10 units, Piperacillin Sodium-Tazobactam Solution Reconstituted 3-0.375 GM q8hours, and Flonase Allergy Relief Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal) scheduled at 8:00 AM.RN K on 8/13/25 at 8:45 AM indicated that she forgot about maintaining the resident's dignity and privacy by avoiding medication administration in the public areas, such as the hallways and the dining area.A review of the Resident's Rights and Facility's Responsibilities (Undated) Policy was conducted on 8/14/25 at 3:00 PM:Residents RightsThe resident has a right to a dignified existence, self- determination, and communication with and access to persons and services inside and outside the facility, including those specified in this (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	section.Dignity, Respect and Quality of LifeA facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1.) evaluate and contact provider with abnormal laboratory findings prior to medication administration of Potassium supplement for Resident #52; 2.)provide assessment, monitoring, and treatment for a Resident with a PEG (percutaneous endoscopic gastrostomy) tube for Resident #27; and 3.) follow standards of practice for Midline intravenous flushing for Resident #29, of three reviewed for standard of practice.Resident #27 (R27) On [DATE] at 9:00 AM, a record review of the R27's Face Sheet and Minimum Data Set/MDS assessment indicated R27 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Unspecified Dementia, severe with other behavioral disturbance, Delusional Disorders, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, and Obstructive and Reflux Uropathy in addition to other diagnoses. R27's Brief Interview of Mental Status (BIMS) Score on [DATE] was 13/15. A score of 13 indicates intact cognitive function. He has a Urinary Catheter and a PEG (Percutaneous Endoscopic Gastrostomy) Tube. In R27 MDS assessment Section GG dated [DATE], revealed no impairment with upper and lower extremities; however, was deemed dependent with eating, toilet hygiene/shower, and lower body dressing, including putting on footwear. Dependent means the helper does all of the effort. The ability to dress and undress above the waist required a Partial/moderate assist, which means the helper does LESS THAN HALF the effort to complete an activity. The helper lifts or supports limbs or trunk and provides more than half the effort. R27, who was noted to have a hearing impairment, was asked to observe his peg tube site on [DATE] at 1:00 PM. R27 had a PEG Tube in place, located on the upper left quadrant of the abdomen. Although there was redness surrounding the PEG site, he denied discomfort at that time. Aside from the redness on the skin area around the site, brownish crusting, dried blood, and yellowish discharge were noted around the site. R27 denied any treatment or dressing change done daily. The Care Plan for R27 was reviewed on [DATE], at 1:00 PM. It revealed: I require tube feeding r/t Dysphagia. Date initiated:[DATE]. Revised on [DATE]. Goal: I will remain free of side effects or complications related to tube feeding through the review date. Date initiated [DATE], Target date: [DATE]. I have an alteration in gastrointestinal status r/t gastrostomy status. Date initiated: [DATE]. Revision on [DATE]. Goals: I have minimized my risk factors contributing to discomfort, complications, or increased signs and symptoms of gastrointestinal alterations through the review date. Date Initiated: [DATE]. Revision on [DATE] and Target Date: [DATE]. I am on Enhanced Barrier Precautions (EBP) r/t Foley and PEG Tube. Date initiated [DATE]. Revision on: [DATE]. Goal: I will remain free from infection. Date initiated: [DATE]—revision on: [DATE], and Target Date [DATE]. I am currently NPO r/t dx of Dysphagia and am receiving enteral feeds via PEG tube. Date initiated [DATE]. Revision on [DATE]. Goal: I will not develop complications related to obesity, including skin (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through the review date. Date initiated: 12/01/ 2021, Revision on: [DATE] Target Date: [DATE] A review of the Treatment Administration Record and Physician's Order on [DATE], at 1:00 PM revealed that no daily treatment, monitoring, or dressing change was ordered for the PEG site found for R27. According to the Administrator's interview on [DATE] at 3:30 PM, the Administrator replied: There are no current residents with a Feeding Tube in the facility. But let me double-check with staff. The CMS 802 Form did not reflect any resident with a feeding tube. However, during the initial tour on [DATE], R27 was noted to have a peg tube. R27's CarePlan was reviewed and revealed: Care Plan I require tube feeding r/t Dysphagia. Date initiated:[DATE]. Revised on [DATE]. Goal: I will remain free of side effects or complications related to tube feeding through the review date. Date initiated [DATE], Target date: [DATE]. I have an alteration in gastrointestinal status r/t gastrostomy status. Date initiated: [DATE]. Revision on [DATE]. Goals: I have minimized my risk factors contributing to discomfort, complications, or increased signs and symptoms of gastrointestinal alterations through the review date. Date Initiated: [DATE]. Revision on [DATE] and Target Date: [DATE]. I am on Enhanced Barrier Precautions (EBP) r/t Foley and PEG Tube. Date initiated [DATE]. Revision on: [DATE]. Goal: I will remain free from infection. Date initiated: [DATE]—revision on: [DATE], and Target Date [DATE]. I am currently NPO r/t dx of Dysphagia and am receiving enteral feeds via PEG tube. Date initiated [DATE]. Revision on [DATE]. Goal: I will not develop complications related to obesity, including skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through the review date. Date initiated: 12/01/ 2021, Revision on: [DATE] Target Date: [DATE] Nurse P stated that they did not apply a dressing to the site. The PEG rube is not being used and not flushed. Nurse P said, There has been no treatment ordered to the site. We don't flush because it is not in use. The certified Nurse aide (CNA) reports any abnormalities to the nurse; however, since we don't use the PEG for feeding or medication, we don't get to see the site often. When asked why the treatment/care of the Peg site was performed without the surveyor's presence, despite having requested to be present, Nurse P replied that the request may have been misunderstood. She thought I was there to observe the flush. The nurse attempted to flush and tugged on the tube to check the site on [DATE], at 11:30 AM. R27 yelled, stating, It hurt. The peg area was covered with a newly applied dressing, and around the tube is saturated drainage (moderate amount) as it was absorbed by the T-gauze pad, seen described by Nurse P as serosanguinous discharge on the T-sponge dressing secured with a tape at the peg tube site. She stated that they had just applied the dressing to the site because they noticed drainage with a tinge of blood on it. The Doctor has been notified of the findings. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNA assigned to R27 was interviewed on [DATE] at 11:30 AM and indicated that there was no treatment and no daily dressing, as she had noticed. Noted on [DATE]A NEW treatment orders were added: One time only, an Order was noted on [DATE] at 9:15 AM: Cleanse the Peg tube site with normal saline, pat dry. Apply T drain and secure with tape. Cleanse the skin surrounding the PEG tube site with normal saline and pat dry. Apply T drain and secure with tape. Notify Provider of any signs of infection or drainage. Every night shift and as needed. The Order was written as active on [DATE] at 9:45 AM (After the surveyor inquired and requested to see the peg site and the flush on [DATE] at 8:00 AM) Flush the Peg tube with 30 mL every 8 hours for maintenance. The Order was placed and active on [DATE], at 16:00. After the surveyor inquired on [DATE], it was revealed by the DON and Administrator that there was no flushing or treatment at the site because the tube was not in use for feeding. Monitor the Peg tube site for signs of infection and notify the Provider accordingly every shift/ Night. Order Start Date was [DATE] Noted NEW Peg tube related treatment orders were entered [DATE] and [DATE]. There were no treatment orders prior. On [DATE] at 9:31 AM, the Director of Nursing wrote in the progress note: When the nurse assessed the PEG Tube site today, scabbing and crusted drainage were noted. MD (Name mentioned) notified via phone. New orders to clean the area surrounding the PEG site with normal saline. Nurse cleansed site with the light serosanguinous drainage was noted. Policy on Peg tube Care was requested and reviewed. on [DATE]. The Policy entitled Enteral Nutrition Guidelines (Revised Date: [DATE] indicated: Purpose: A feeding tube is used to deliver a liquid feeding formula directly to the stomach, duodenum, or jejunum. This applies to both nasogastric and gastrostomy feedings. Procedure: 19. The skin around a gastrostomy or jejunostomy is kept clean and free from irritation and/or infection. The site is evaluated for signs of: erythema tenderness drainage and erosion . Documentation . 3. Physician orders are documented in the medical record and must include the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Stoma care (if a gastrostomy or jejunostomy .4. The care plan includes specific details on: a. who should provide the care. and how often; b. what supplies and equipment needed; c. how the care is undertaken; d. immediate and long-term goals of the enteral feeding; and e. anticipated duration of enteral feeding . R27's Plan of Care did not reflect any of the above Facility Peg tube Policy (Enteral Nutrition Guidelines) specifically to his PEG Tube site care. Resident #29 (R29) During Medication Administration observation conducted on [DATE] at 8:15 AM, R29 was observed during Medication Pass. Nurse K stated R29 started infusion of his scheduled IV medication through Midline ne at 7:45 AM. It is therefore due to be removed and done with infusion. It usually takes an hour for it to completion. Nurse K was at the [NAME] Wing Hallway by the MedCart across the Nurses station. Nurse K was observed while she unhooked the empty antibiotic bulb by the IV Port Line without wearing PPE (gloves.). Nurse K examined if the reconstuted medication inside the bulb has been completely emptied. After verifying that the antibiotic infusion was completed and emptied, without gloves on, she discarded the [NAME] to the medcart trash, peeled the alcohol wipes and flushed the line wit a 10 cc of sterile normal saline irrigation syringe. Nurse K did not realize doing the flushing in the hallway without gloves and in front of others to see (visitors, other residents and staff). Nurse K did not wash or sanitize her hands and did not wear gloves. Nurse K wiped the end cap of the IV Midline with alcohol wipes with her bare hands. R29 also received a nasal spray administered through both his nostrils in the hallway after his PICC Line antibiotic was unhooked. Nurse K was observed not wearing gloves upon administering the nasal spray. According to R29 EMR reviewed on [DATE] at 12:00 PM, it revealed that R29 was admitted to the facility on [DATE]. He was [AGE] years old, admitted with a diagnosis of Type 2 diabetes Mellitus with Foot Ulcer, Non-Pressure chronic Ulcer of the Left Heel and Midfoot with unspecified severity, and osteomyelitis of the left foot and ankle, in addition to other diagnoses. R29 was prescribed the following: Lantus Solostart Subcutaneous Solution Pen-Injector 100 Unit/ML (Insulin Glargine) 10 units, Piperacillin Sodium-Tazobactam Solution Reconstituted 3-0.375 GM q8hours, and Flonase Allergy Relief Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal) scheduled at 8:00 AM. RN K on [DATE] at 8:45 AM indicated that she forgot about maintaining the resident's dignity and privacy by avoiding medication administration in the public areas, such as the hallways and the dining area. A review of the Med Pass Guidelines and Nasal Inhaler Policy was conducted on [DATE] at 3:00 PM: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Administration for Nasal Inhaler, spray, and pump Administration Policy: To administer nasal Medications in a safe and accurate manner. Supplies needed: inhalation or spray medication. tissue or gauze glove Medication Administration Record (MAR) Procedure: . 3. Provide for resident privacy.Explain the procedure to the resident and inform him about what medication is being administered 5. Wash hands (examination gloves may be worn) . 19. Wash hands . The Medication Pass Guidelines (Revised Date: [DATE]) was reviewed. Purpose: To assure the most complete and accurate implementation of physician's medication orders and optimize drug therapy for each resident by providing the administration of drugs in an accurate, safe, timely and sanitary manner and to systematically distribute medications to residents in accordance with state and federal guidelines. Procedure:1. Follow infection control practices. complete hand hygiene prior to medication preparation for each medication pass between resident medication administrations, after direct resident contact and at the completion of medication pass . Use sterile syringes and needles for all injections . According to homecare.med.umich.edu your midline lumen must be flushed to prevent infection and keep the blood from clotting. Cleaning your hands explained in various ways by 1. washing hands with soap and water,2. using a hand sanitizer 3. and instructions on hot to handle sterile supplies was emphasized with great importance. The purpose of the Midline Flush Protocol is to:1. Prevent clots: Regular flushing prevents blood from clotting in the catheter lumen. 2. Prevent infection: Aseptic technique used during flushing helps prevent microbial contamination. 3. Ensure Patency: Flushing confirms the catheter is open and functioning correctly for medication or fluid administration. A midline flush protocol involves: aseptically flushing a midline catheter . Key steps include washing (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands, scrubbing the catheter cap with alcohol pad, connecting the prefilled saline syringe, followed by hand hygiene . Resident #52 A review of Resident #52's medical record revealed an admission into the facility on [DATE] and date of discharge [DATE] with diagnoses that included fracture of right humerus and greater trochanter of right femur, chronic kidney disease, heart failure, atrial fibrillation, and hyperkalemia (a medical condition where the body has high levels of potassium in the blood). A review of Resident #52's medical record of a progress note dated [DATE] revealed the Resident had died at the facility: Resident was visiting family and family came and got staff to toilet resident at 1350 (1:50 PM). Resident used the bathroom and stated to the staff that she had no power to get up and that she couldn't stand up-it took three staff to get resident up off the toilet- and place her back in her bed at 1352 (1:52 PM). Staff notified nurse and nurse went to grab the vital cart to take her vitals when staff alert nurse that she went unresponsive. Nurse initiated CPR (cardiopulmonary resuscitation) straight away and a code was code (called) for all nurses to report to her room. 1408 (2:08 PM) MMR (mobile medical response) arrived. CPR continued. Time of death called 1447 (2:47 PM). A review of Resident #52's laboratory test with a collection date on [DATE] at 9:30 AM, received date on [DATE] and a reported date on [DATE] at 15:42 (3:42 PM), revealed a Basic Metabolic Panel (BMP) completed with Potassium of 5.8 mEq/L with a reference range of 3.5-5.3, flagged as H high. A review of the progress notes dated [DATE] at 8:28 PM revealed, Note Text: Results from labs ordered with xray 7/29. Sodium (L (low)) 134, Potassium (H (high)) 5.8, Anon Gap (L) 10.8, Glucose (H) 122, GFR (L) 48, BNP (CH (critical high)) 730.7-NP (Nurse Practitioner) called with CH repeat in 2 weeks both BMP and BNP. A review of Resident #52's medication orders revealed an order for Potassium Chloride ER (extended release) 20 MEQ. Give 1 tablet by mouth one time a day for low potassium, with a start date [DATE] and discontinue date [DATE] at 2:00 PM. A review of the Medication Administration Record revealed the medication was ordered for 8:00 AM and the Resident received the potassium medication in the morning on [DATE]. The medication had not been discontinued after the abnormal high laboratory Potassium level was received at the facility on [DATE] and had been administered in the morning on [DATE]. On [DATE] at 11:36 AM, an interview was conducted with the Director of Nursing regarding Resident #52's laboratory results for Potassium high at 5.8 received on [DATE], the order for medication Potassium was not discontinued and Nurse K administered the medication on [DATE] in the morning. The DON was asked why the Potassium was given when lab results were high. The DON responded that she had seen the potassium was high and stated, I don't know why the NP didn't discontinue the Potassium when they were called with the labs. When asked what the Nurse should have done, the DON reported that the Practitioner could have discontinued it, It should have been passed on in report that her potassium was elevated, the Nurse could have held it and called the doctor prior to giving the medication. The DON stated, We discontinued it that morning, she only got that morning dose then it was discontinued. On [DATE] at 12:08 PM, an interview was conducted with Nurse K who had administered Resident (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellspring Lutheran Services	725 West Genesee Frankenmuth, MI 48734

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#52's medication in the morning on [DATE] that included the Potassium supplement. The Nurse was asked if she was aware of the high Potassium laboratory value prior to administration of medication to Resident #52. The Nurse reported she had not received the information in report and had not reviewed the laboratory results. The Nurse stated, Had I known (of the high potassium level) I would not have given the Potassium and reached out to the provider. The Nurse was asked when she became aware of the elevated Potassium level and reported she had not been aware until now and reported that a high level like that would be passed on in report, so they are aware of the results. The Nurse confirmed she had access to laboratory results in the medical record. On [DATE] at 9:07 AM, an interview was conducted with Nurse Practitioner (NP) O regarding Resident #52's report of abnormal Potassium level. The NP was asked if they were made aware of the Potassium laboratory levels with the BNP levels. The NP was unsure and reported ordering for repeat labs for the BNP elevated level. A review of the Resident admitting to the facility with list of medication to hold the bumetanide (a diuretic medication) and spironolactone (potassium-sparing diuretic), but the Potassium was continued. The NP indicated that usually when the diuretic was stopped, then the potassium supplement was discontinued as well, but the Resident could have other conditions to verify the need for the Potassium supplement to be continued. The NP reported that the physician would review the medications upon admission. The NP reported that routinely they would hold the potassium with an abnormal high lab value, assess the resident and treat if symptomatic or transfer to the hospital if needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a timely response to a change in condition for Resident #65; assess/respond to abnormal vital signs for Resident #52 and Resident #65; and ensure antibiotics were ordered and administered timely for Resident #63, for three residents (#52, #63 and #65) of four residents reviewed for a change in condition and antibiotic administration, resulting in a delay in treatment, increased abdominal pain and hospitalization for Resident #65, and a delay of antibiotics for Resident #63 with the potential for continued infection and delay in assessment/treatment of abnormal vital signs for Resident #52.Resident #52: A review of Resident #52's medical record revealed an admission into the facility on [DATE] and date of discharge [DATE] with diagnoses that included fracture of right humerus and greater trochanter of right femur, chronic kidney disease, heart failure, atrial fibrillation, and hyperkalemia (a medical condition where the body has high levels of potassium in the blood). Further review of the medical record revealed the Resident had gone unresponsive, cardiopulmonary resuscitation was initiated and the Resident died at the facility. A review of Resident #52's medical record of documented Pulses revealed the following abnormal vital signs of heart rate (Pulse): [DATE] at 11:57 PM, Pulse of 58 bpm (beats per minute). [DATE] at 11:57 PM, Pulse of 59 bpm. [DATE] at 6:46 PM, Pulse of 45 bpm. [DATE] at 10:03 PM, Pulse of 50 bpm. [DATE] at 12:54 AM, Pulse of 46 bpm. [DATE] at 7:48 PM, Pulse of 42 bpm. [DATE] at 10:15 PM, Pulse of 37 bpm. [DATE] at 1:22 PM, Pulse of 42 bpm. [DATE] at 2:10 AM, Pulse of 56 bpm. [DATE] at 12:38 AM, Pulse of 54 bpm. [DATE] at 12:38 AM, Pulse of 58 bpm. A review of the progress notes for Resident #52 revealed a lack of assessment, contacting the practitioner and follow-up interventions or monitoring by rechecking the heart rate of the abnormal heart rates obtained. On [DATE] at 9:07 AM, an interview was conducted with the Nurse Practitioner (NP) “O” regarding Resident #52's care. The NP was asked about abnormal pulse rates and reported that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	parameters for below 60 on a regular basis and above 90 on a regular basis with abnormal and communicated to the practitioner. When queried regarding assessment of the Resident, the NP indicated that the vitals would be rechecked and if it remained high or low then call the practitioner. The pulses for Resident #52 were reviewed. The NP indicated that at 50 and asymptomatic, need to do assessment to see if asymptomatic or having symptoms, at 37 and 42, if rechecked and stayed low, “I would send her out.” The NP indicated that with the abnormal pulse rate, the nurse would need to recheck, do an assessment and notify the practitioner. On [DATE] at 1:19 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #52's abnormal pulse readings. Resident #52's abnormal pulses were reviewed with the DON. When asked about facility policy, the DON reported that vital signs were to be obtained in the morning before medications are administered and in the evening before the medication pass. The DON reported that if the vital signs were out of range, the provider would be contacted. Resident #52's medical record was reviewed with the DON, and it was determined that the vital signs were documented into the medical record when staff were charting and not necessarily when the vital signs were taken. Resident #52's documentation lacked timely reassessment of the abnormal results, assessment of the Resident symptomatic or asymptomatic and the notification of the practitioner. Resident #63 (R63): A record review of Resident 63's (R63) medical chart included medical diagnoses: Cellulitis of the left lower limb (infection of the skin), non-pressure chronic ulcer of left lower leg, Urinary tract infection (UTI), Anxiety, Diabetes Mellites 2 (DM2), need for assistance with personal care. R63 was admitted to facility on [DATE] for rehabilitation. On [DATE] at 10: 40 AM, during an observation of R63 is sitting in a wheelchair in room, and reportedly had just returned from physical therapy, is alert and oriented. During an interview R63 said she was supposed to continue antibiotics when she came to the facility from the hospital for rehabilitation. There was a 3-day delay receiving them. When R63 asked the nurse on duty about the antibiotics, she was told it was because it was not on her medication list. On [DATE] at 10:48 AM, An interview with R63, clarified when she was admitted and she confirmed it was [DATE]; she stated, “I did see the facility doctor the day after I got here ([DATE]) and was told he confirmed my orders for the antibiotics, and they were being ordered that day”. R63 stated, “I did not get the antibiotic until Monday night ([DATE]). I was not happy that it took 3 additional days to get the antibiotics, it is important for healing my infection up”. On [DATE] at 11:59 AM, in an interview with director of nursing (DON) about the process for physician rounds and orders, she stated, “Usually myself or the floor nurse follows with the doctor. All new orders are verbal orders and are entered into at the time of the visit. They may or may not end up as a written order”. On [DATE] at 12:28 PM, in an interview with Nurse manager “A”, she was asked about the process for physician rounding and stated, “Doctor (Dr “E”) comes in 2-3 times a week usually in the early morning; Dr “F” and his Nurse practitioner (NP “G”) round 2-3 times weekly as well”. She stated, “They come in and check in with the nurse on the floor and tell them who they plan to see”. When asked about any orders that come from that visit she stated, “If there are new orders, they stop at the desk and tell the nurse before they leave”. The DON was asked when the orders are put in the computer and she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, “That varies by the nurse but at a minimum by the end of their shift”. On [DATE] at 1:50 PM, an interview was conducted with the Medical Director and admitting doctor Dr “E”, who was asked about frequency and process for rounding. He stated, “I round 2 times a week, the time and day varies depending on the admissions and needs of facility, within 48 hours of admissions is the standard. All the admissions go through me personally” and “I prioritize the order of my visits by admissions, residents with issues noted in my book, and then my scheduled routine visits”. Dr “E” stated, “As far as the process goes, I come into the facility and talk to the nurse on duty. I ask for any updates on the residents I am seeing. I see the residents. If there are any new orders, I discuss them with the nurse on duty, and they enter them. If I am ordering a controlled substance medication, I sign those orders at that time as well”. His response to the expectation of when the ordered medications should be ordered and begin was, “If stock (medications on hand at the facility) then they should start right away and pull from there (the stock on hand), if oral antibiotics are ordered then they should be ordered expedited. the pharmacy delivers 2 times a day so they should get that next dose”. [DATE] at 2:20 PM, in an interview with Assistant Director of Nursing (ADON), she was asked about the process for physician rounding and stated, “the doctor comes in to do rounds and talks to the nurse on duty. If there are orders he tells the nurse. The nurse enters the orders, and a progress note into the system”. The ADON was asked to look at the R63 admission date and she stated, “8/7” and then she was asked the date of the progress note of the physician visit and stated, “8/8”. The ADON was asked to view the order date for the antibiotic, and she stated, “8/11”. She stated, “I put that order in because I had to call the doctor about it”. The ADON was asked, why did you have to call about the order? “Well, the resident asked about her missing antibiotic, so I called the doctor to ask for clarification. We did not realize the antibiotic wasn't on the discharge med list (medication), so it was not ordered or given. I ordered it, and she got a dose that night”. The ADON was asked to confirm that it was the night of [DATE] and she replied, “Yes”. The ADON was asked if the nurses review the physician progress notes, or the discharge plan for admission to the facility and she stated, “No, we just look at the medication list”. A record review of R63's discharge paperwork from the hospital, dated [DATE], on the progress note, dated [DATE], in plan section states, “Left lower extremity cellulitis Reports bumping her left leg about 3 days prior to presentation and suddenly noticing worsening erythema (redness) denies any fever or chills wound continues to weep, however surrounding erythema. patient initially on ceftriaxone and Zyvox (both are antibiotics), ceftriaxone discontinued and started on meropenem (antibiotic) continue routine wound care, CT lower extremity … Plan is to discharge on p.o. (per os/ by mouth) Zyvox the next 24 hours”. Review of final discharge summary from the hospital on [DATE], plan states “Left lower extremity cellulitis . Patient has been started on ceftriaxone and Zyvox in the emergency room, and appears to be improving white blood count (WBC) count continues to trend downward… Cat Scan (CT) of lower extremity 8/3 demonstrated extensive subcutaneous edema with cellulitis, no evidence of abscess of the left leg, continued with zyvox (started on 7/31) and meropenem (started on 8/4)…”. The resident was discharged from the hospital on [DATE] with lower left extremity cellulitis and a Urinary tract infection (UTI) and was receiving Zyvox and Meropenem. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of R63's admission progress notes from Physician Dr “E” from [DATE] with a late entry that was written on [DATE], “Antibiotic therapy was initiated for the cellulitis, with infectious disease involvement. The patient is currently continuing with Zyvox… Her left lower extremity still shows some redness…”. A record review of the physician's orders for R63 revealed, “Linezolid Oral Tablet 600 MG (Zyvox) Give 1 tablet by mouth two times a day for Cellulitis, UTI for 10 Days Pharmacy Active [DATE] at 20:00 -stop [DATE]”. According to the facility's medication administration policy, the purpose stated is, “To assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing the administration of drugs in an accurate, safe, timely and sanitary manner…”. Change of Condition Resident #65: On [DATE] at 12:15 PM, Confidential Person “J” was interviewed about Resident #65. She said she visited the resident 2 days ([DATE]) after Resident #65 was admitted to the facility on [DATE]. The Confidential Person said the room was hot that day and there was no fan. She said in the hospital the resident was alert, walking with assistance, talking and sitting in a bedside chair. The Confidential Person “J” said she visited the resident again on [DATE] and the facility staff said Resident #65 had not been out of bed and the resident appeared to be declining. A record review of the electronic medical record indicated Resident #65 was admitted to the facility on [DATE] with diagnoses: recent hernia surgery, pain, diarrhea, and COPD/emphysema. A Brief Interview for Mental Status/BIMS score of 15, indicating full cognitive abilities was assessed on [DATE] after admission. A record review of the progress notes identified the following: [DATE] at 12:42 PM, a “Physician Extender” note “History of Present Illness: (Resident #65) a [AGE] year-old female with a history of COPD, was admitted to (the facility) for physical conditioning following hospitalization for an incarcerated right inguinal hernia. The patient initially presented to the hospital with complaints of abdominal pain and was diagnosed with an incarcerated inguinal hernia in the right lower quadrant. On [DATE]th, she underwent a right inguinal hernia repair with mesh and a small bowel resection. During her hospital stay, she developed an ileus, from which she has since recovered. Currently (the resident) is experiencing severe nausea and vomiting… She is alert and oriented with stable vital signs… Ordered stat abdominal x-ray to rule out ileus or obstruction…” A record review of the vital signs for Resident #65 revealed the following: Blood Pressure: Identified low on [DATE] at 11:48 PM- 93/57; high on [DATE] at 12:56 AM 140/100; very low on 7/26//2025 71/51. Pulse: high on [DATE] at 11:42 AM 111 beats/per minute (bpm); [DATE] at 7:53 PM 118 bpm, [DATE] 109 bpm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Temperature: high 99.6 [DATE] and 100.4 [DATE] at 11:42 AM. Respiratory Rate: high on [DATE] at 11:42 AM 24 breaths/min; high [DATE] 26 breaths/min. Oxygen saturation rate: Low [DATE] at 11:42 AM 92% room air; Low [DATE] at 5:10 PM 93% room air; [DATE] at 10:46 AM 91% room air. Pain: “8” high on [DATE] at 2:34 PM. Resident #65 had abnormal vital signs beginning [DATE]. Further review of the progress notes for Resident #65 identified the following: [DATE] at 2:25 PM, a “Health Status Note, “NP (Nurse Practitioner) notified of patient nausea and inability to take the Zofran pill due to it making the nausea worse…” [DATE] at 6:46 PM, a “Health Status Note revealed, “NP (Nurse practitioner) in doing rounds. New orders. STAT Flat plate 2 view of abdomen”. [DATE] at 3:54 AM, a “Health Status Note- X-ray completed at 9:07 PM awaiting results.” [DATE] at 11:27 AM, a “Health Status Note” provided, “Received X-ray results small bowel ileus vs obstruction…” A review of the STAT X-ray ordered for Resident #65 identified the order did not indicate it was to be completed STAT. The “Radiology Results Report” indicated the examination date was [DATE] at 4:20 PM and the results were reported to the facility on [DATE] at 6:40 PM. This was approximately 24 hours after the orders for the STAT X-ray were mentioned. The STAT (immediately) X-ray was ordered on [DATE] at 6:46 PM, per the progress notes. The results were documented in the medical record on [DATE] at 11:27 AM. This was greater than 1 ½ days later and Resident #65 continued to complain of abdominal pain, nausea and vomiting. An additional progress note for Resident #65 dated [DATE] at 1:25 PM provided, “Health Status Note, patient c/o (complains of) abdominal pain and nausea, stated has vomited bile. Requesting to go to the hospital… order received to send to hospital…” On [DATE] at 3:47 PM, the Director of Nursing/DON was interviewed about Resident #65. Reviewed with the DON, that the resident had repeatedly complained of increasing abdominal pain. Reviewed the resident's vital signs with very low blood pressure, high pulse, increased respiratory rate, decreased oxygen saturation. The nurses did not document they were aware of the abnormal vital signs or what interventions were enacted. Reviewed the order documenting that a STAT abdominal X-ray was to be completed ([DATE]). The X-ray was completed on [DATE] at 4:20 PM and reported to the facility on [DATE] at 6:40 PM and reviewed in a progress note on [DATE] at 11:27 AM. The X-ray was not completed STAT (immediately) and the resident's abnormal vital signs were not reviewed in the assessments or notes. Resident #65's condition continued to decline, and she was transferred to the hospital emergency room on [DATE] at approximately 1:25 PM. The DON reviewed the resident's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record and identified the date [DATE] at 4:20 PM that the X-ray was completed for Resident #65. She also reviewed the time the results were provided to the facility ([DATE] at 6:40 PM). She said the results were sent to the facility on a fax and she was not sure when the nurses would have received them. Reviewed the resident's condition was declining and the X-ray results were not mentioned in the progress notes until the next day [DATE] and then the resident was transferred to the hospital. A review of the facility policy titled, “Change of Condition,” review date [DATE] provided, “Policy: It is the policy of (the facility) to enable staff to evaluate and manage residents at the facility and avoid transfer to a hospital or emergency room by recognizing an Acute Change of Condition and identifying its nature, severity, and causes… An acute change of condition is defined as a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains… The licensed nurse completes an assessment of the resident and based on the findings notifies the physician of any change of condition… Continued monitoring and assessment of the resident is documented in the resident's clinical record.”

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision and safely assist residents to prevent falls with injury for one resident (Resident #7) of four residents reviewed for accidents with falls, resulting in R7 falling from their wheelchair, requiring a hospital emergency room visit with laceration repairs.Findings include: Resident #7 (R7):Record review of Resident 7's (R7) quarterly Minimum Data Set /MDS revealed Brief Interview of Mental Status (BIMS) of 99, defined as severely cognitively impaired never/rarely made decisions. R7 was assessed as dependent in all activities of daily living (ADL) and transfers. Medical diagnoses included: End Stage Renal Disease, Cardiac Defibrillator, Anxiety Disorder, Major Depressive Disorder, Dementia with Behavioral Disturbance. R7 was in long term care/LTC at the facility and was admitted to their hospice care on 7/23/2025.On 8/12/2025 at 2:50 PM, an observation was made of R7 who was in the hallway by the west hall nursing station and sitting in a Geri chair (a large reclining mobile chair) that was in a slightly reclined position with his feet up on footrest. He is yelling out give me 2 of them and I want to go as staff and visitors pass through the area. On 8/13/2025 at 8:10 AM, R7 was observed in his room. He was resting quietly with his eyes closed and sitting in a Geri chair that is in a reclined position, his feet up on the footrest. Soft touch call light was sitting on the bed out of reach.A record review of the video clip from the facility's cameras on 7/12/2025 was timestamped starting at 2:08:04. This was time prior to and just after the recording of R7's fall. The following is a summary of the videos review: Nurse on Duty LPN D was standing behind the nursing station on the west hall at the desk. CNA C was sitting in a chair to the right back side of the nursing station; she is looking down at a cell phone and appears to be reading/scrolling through its contents. CNA C has a water bottle with her and is seen drinking from it while continuing to look at the phone. LPN D is seen leaving the desk area and proceeded to walk down west hall toward residents' rooms. At this point in the video, R7 can be seen using his feet to propel himself in the wheelchair and he was heading from the area in the back right section of the nursing station going toward west hall resident rooms. As the video continues, CNA C is seen sitting in the same chair and did not look up from the cell phone. R7 continued to propel himself and was heading towards another resident that was resting in a Geri chair by the front right area of the west hall nursing station. In the video, R7 collided into a resident that appeared to be there sleeping in a Geri chair. R7 kept going forward in his wheelchair and hit the other Geri chair 3-4 times. At this point the video showed that CNA C gets up from their chair, walked over to R7's wheelchair and grabbed the handles. The CNA did a 3-point turn (diagonally, back and forth) appearing to try and turn R7 around. They were in a small area on the right side of the west hall nurses' station. She pulled back to turn the resident for the third time and R7's feet appeared to become tucked under the front of the wheelchair and in the last forward motion of the turning lunged the resident forward out of his wheelchair. R7 did not make any attempt to stop/brace or protect himself and he fell forward to the floor; face first on the front/left side of his body, where he continued to stay for the remainder of the video.During R7's fall, CNA C could be seen with a delayed partial reach toward the resident but R7 was already too far forward in the forward motion to assist. After witnessing R7's fall to the ground, the CNA C did not motion toward R7 to render care directly, she looked at him, walked back toward the west hall and looked down the hall. She grabbed a vital signs machine (monitor for heat rate, blood pressure, temperature and oxygen saturation) and walked in the direction of R7 as LPN D came back into the video frame walking from down the west hall and returned to the nursing station desk. After LPN D saw CNA C, she hurried over to R7 who was laying in the same position as when he originally fell, the video clip ends. (there was no audio to this footage)A record review of the facility reported incident (FRI) and the investigation report provided by the facility indicated CNA C s written statement in the 5-day report to be, CNA C was pushing R7 back to his room. R7 leaned forward and fell at the wheelchair hitting his head on floor and that LPN D's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbal statement was indicated to be, I was giving meds to another resident. When I was returning from doing that the Agency CNA (CNA C) asked me to come around to the nurse's station. I came around the corner to find R7 on the floor face first. I asked her what happened, she said he fell forward out of the wheelchair. I immediately called the other nurse to come and help and called for an ambulance. The agency CNA C said, he was self-propelling, and I assisted him in re-directing him away from the other resident sitting at the nurse's station. LPN D's statement further exclaimed, I did not witness the fall. and I observed he did not have his foot pedals on and although the Agency CNA (CNA C) indicated he was self-propelling I provided verbal education to her on foot pedal use. As for myself, I do not know what happened. I believed this to be an accident.On 8/13/25 at 11:50 AM, A call was placed to CNA C. The message received was, (Cellular provider) wireless is no longer able to connect the calls to this number. On 8/13/25 at 12:04 PM, During a follow up interview with the Administrator, she was asked about how staff received education and in-services, and she stated, The staff does quarterly education in a (computer-based education program). She was asked how the facility verified that agency staff had received educational trainings and reviewed policies and procedures, she responded We have a contract with the agencies, it ensures that the onboarding process has been done, it is a mini orientation to the facility policy and procedures and education requirements. I preview those files; I do not hold those employee files here they are kept with their agencies. The administrator stated, Unfortunately that the staffing agency CNA C worked for went out of business on July 27th. Requested the Administrator to provide any contract, education, orientation documents for this CNA and agency into (an electronic document storing system).On 8/14/2025 at 11:00 AM, during an interview the Director of Nursing/DON was asked if she had any reported issues about CNA C and she stated, This was the first and only time she worked here at this facility. She was asked about if and how the facilities policy and procedures, and education requirements are applied to the agency staff, she stated All facility policy & procedures and education requirements apply to the agency staff, they have been completed at the agency and agreed upon in the signed contracts with the agency.On 08/14/2025 at ~12:30 PM observation was made of R7 in his room, he is sitting in his wheelchair eyes closed, there is a meal tray attached to the front of the chair, and it is holding a partially covered uneaten plate of food.On 8/14 at 1:00 PM, according to the interview with LPN D nurse in charge of west hall on 7/12/2025 prior to R63 fall that early morning, I was at the nurse's station and left to go pass a medication to a resident down the west hall, when I walked away the resident was still sitting up by the desk. Asked LPN D why R7 was at the desk instead of bed at 2 am and she stated, because he was having some behaviors that evening, like he does often. She continued I came back down the hall, and the agency CNA (CNA C) was standing in the hall opening at the desk and she told me he (R7) just leaned forward and fell. LPN D further explained that she walked around the desk to see what was going on and R7 was laying on the floor and she could see that he needed assistance, I started to assess the resident (R7) and called for help from the other nurse, I also called for the ambulance. She states, that when she was assessing R7 she, noticed the wheelchair foot petals were attached but not in use, they were off to the side and I did say to her later that we need to use foot pedals when transporting a person in a wheelchair. Asked LPN D if CNA C offered to or assisted with resident after the fall and she said, No, and that is why I called for additional assistance. Asked LPN D had she ever worked with CNA C before? she replied, No, she was an agency CNA and this was her first time working here, I did not know her prior to that shift. Asked LPN D, Did you observe CNA C eating, drinking or on any personal devices other than on her break? She replied, I believe she was on her phone at some point, but I can't be sure. She stated, she was surprised but felt that CNA C was very nonchalant and showed a lack of empathy after R7's fall, as if she was unaffected. A record review of R7's chart revealed he had fallen from his wheelchair on 7/12/2025 and again on 8/6/2025. After both occurrences R7 was sent out to the emergency department and received closure with staples and sutures for lacerations obtained during those falls. The hospital notes from 7/12/2025 indicated, Pt arrives from (the facility) for a fall out of a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair. The hospital notes from 8/6/2025 indicated, ER for a fall . Per EMS, the patient threw himself out of his wheelchair which apparently is not an uncommon occurrence for him .A record review of R7's care plan indicates areas of focus as, I have a risk for falling r/t Weakness, difficulty walking, Interventions: As much as possible, based on my habits, help me anticipate and meet my needs; For my safety, I require anti roll back brakes on my wheelchair; and For my safety, I require anti tippers on my wheelchair. A record review of R7's progress note from 7/11/25 at 15:38 PM, Patient was returned from dialysis this morning and has been self-propelling/wandering since that time, yelling out and chanting phrases repetitively.A record review of R7's progress notes 7/12/2025 at 03:25 AM, Note Text: This nurse writer had gone to respond to a request for a prn sleeping pill at 02:08 a.m. and when returning to nursing station area on duty agency aide was standing there and states resident had fell. Upon coming around nurse's station resident was observed lying face first in front of wheelchair on floor with a significant amount of blood noted. When on-duty agency aide (CNA C) was asked what happened she states, I was pushing him in w/c his feet grabbed, and he went forward. Resident noted to have no wheelchair pedals at time of occurrence. Call for assistance from additional staff made and resident was log rolled to side and a large laceration mid forehead was noted as well as pupil's unequal at this time. 911 called. A record review or R7's progress notes from 8/6/2025 at 17:30 PM, Note Text: Nurse was on lunch break when page came over system stating there had been a fall. Nurse and other nurse from unit ran to assess resident. Upon entering the resident's room nurse saw copious amounts of blood on floor and resident on floor yelling. Aide verbally told nurse that resident had fallen out of wheelchair. Aide stated he had rounded on resident and toileted him less than an hour previous and resident was waiting in room for dinner tray with door open to keep an eye on him as he toileted other patients. A record review of the facility job description for the LPN updated 7/30/2020, stated under position summary, Provide quality nursing care to residents; Implement specific procedures and programs; coordinate work within the department, as well as other departments; Report pertinent information to the immediate supervisor: respond to inquiries or requests for information; assist the immediate supervisor with tasks to support department operations and according to LPN essential job functions, Responsible for the supervision of all nursing activities on the unit and Responsible for the interpretation and adherence of the policies and procedures for the personnel, patients, medical staff and public. With the acknowledgement of, Acceptable job performance includes completion of the job responsibilities as well as compliance with the policies, procedures rules and regulations.A record review of the facility job description for the CNA updated 7/30/2020, stated under position summary, Provide quality nursing care to residents; Implement specific procedures and programs; coordinate work within the department, as well as other departments; Report pertinent information to the immediate supervisor: respond to inquiries or requests for information; assist the immediate supervisor with tasks to support department operations and under knowledge and skills lists, Efficient time management and prioritization of work and Communicate and interact effectively and tactfully with resident.peers and supervisors. According to essential job duties, Knowledgeable of the individualized care plan for the residents and provide support to the resident according to the care plan. and Attend the individual needs of residents which may include.transferring.communication, or other needs in keeping with individuals care requirements; Adhere to all organization and site-specific policies and procedures. With the acknowledgement of, Acceptable job performance includes completion of the job responsibilities as well as compliance with the policies, procedures rules and regulations.According to a record review of the facility's Cell phone and electronic devices guidelines that Personal cell phones should not be used in patient care areas or other employees work areas throughout the building.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary management and care of an indwelling urinary catheter drainage bag to ensure it was not sitting on the floor for 1 resident (#62), resulting in the potential for complications including infection, obstruction of urine and a decline in condition. Urinary Catheter Resident #62 On 8/12/2025 at 11:41 AM, Resident #62 was observed lying in bed sleeping. His bed was in a very low position and the urinary catheter bag was in a white cloth bag on the floor; it was not hanging freely to drain and was pushed against the floor. A record review of the Face sheet and electronic medical record indicated Resident #62 was admitted to the facility on [DATE] with diagnoses: Parkinson's disease, stage 4 sacral pressure ulcer, osteomyelitis of vertebra, sacral and coccygeal region, neuromuscular dysfunction of the bladder, right lower leg contracture, diarrhea, and aphasia. The resident was receiving Hospice services. On 8/13/2025 at 10:35 AM, Resident #62's urinary catheter bag was observed on the floor in a cloth bag. A review of the physician orders for Resident #62 identified the following: Catheter care q (every) shift and PRN (as needed). Apply strap to secure placement of catheter tubing and ensure dignity bag is placed on drainage bag, date revised and started 8/8/2025. There was no mention of the urinary catheter bag was not touching the floor to ensure unobstructed urine flow and prevent potential contamination. According to the Centers for Disease Control and Prevention/CDC: Indwelling Urinary Catheter Insertion and Maintenance: . Maintain Unobstructed Urine Flow: Maintain the bag below the level of the bladder. Keep the urine bag off the floor. A review of the Care Plans for Resident #62 identified the following: I have 16fr 30cc indwelling Foley Catheter: Neuromuscular dysfunction of bladder, date initiated 8/8/2025 and revised 8/11/2025. A review of the interventions indicated there was no mention of keeping the catheter bag off the floor. On 8/14/2025 at 1:10 PM, Resident #62 was observed lying in bed, awake. The resident's urinary catheter bag was sitting on the floor with no dignity bag. The urine in the tubing was very dark and the room had a very strong odor. The Infection Prevention and Control Nurse/IPC AA was present during the observation and reviewed with her the urinary catheter bag was on the floor each day of the survey: 8/12/25, 8/13/25, 8/14/25. The IPC Nurse said the urinary catheter bag should not have been on the floor and she would talk to the staff. A review of the facility policy titled, Indwelling Catheter Care, dated revised October 2017 provided, Policy: Routine catheter care helps prevent infections and other complications and is usually performed daily. Inspect the catheter and tubing periodically to detect compression or kinking that could obstruct urine flow. Keep the drainage tube and collection bag lower than bladder at all times. Ensure bag and tubing is not lying on the floor. Empty the collection bag at least every 8 hours. Drainage collection bag should be placed in a privacy bag.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview and record review, the facility failed to ensure assessment of measurements for a midline catheter was completed and the midline catheter was flushed appropriately for one Resident #29, of one reviewed for intravenous catheters.A review of Resident #29's medical record revealed an admission into the facility on 7/23/25 with diagnoses that included acquired absence of right toe(s), diabetes with foot ulcer, ulcer of left heel and midfoot, and acute osteomyelitis, left ankle and foot. Further review of the medical record revealed the Resident had a Midline catheter that was used to administer intravenous (IV) antibiotics. On 8/12/25 at 12:45 PM, Resident #29 was observed in their room, laying on the bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about receiving antibiotics. The Resident reported getting IV antibiotics through a midline catheter. An observation was made of a Midline catheter dressing to the right arm. The Midline catheter had an external catheter, and the insertion site was covered with a dressing. The dressing and the external catheter were covered with stretchy dressing. The date of when the dressing was changed was not visualized on the dressing, the Resident reported they had changed the dressing but was unsure of the day. A review of Resident #29's medical record of the Treatment Administration Record (TAR) revealed a dressing change was completed on 7/24/25, 7/31/25 and 8/7/25. The order for the dressing change was to Change Midline dressing every 7 days. Measure external catheter length and arm circumference on admission, weekly, with each dressing change, CM=External catheter length in centimeters, ARM=Arm Circumference in centimeters, every night shift every 7 day(s) for dressing change. The documentation for the Midline dressing change for 7/24/25 and 8/7/25, lacked documentation of the external catheter length and the arm circumference. A review of Resident #29's progress notes dated 7/31/25, revealed measurements of 1 cm (centimeter) and 31 cm. A review of the Admit/Readmit Screener, dated 7/24/25, revealed Section C. Skin Integrity, description: midline to RUE (right upper extremity) 18 g (gauge). There was a lack of documentation of the measurements of the external catheter and the arm circumference. A review of Resident #29's care plan revealed a Focus: I have an 18g midline to my right upper arm. I have the potential for catheter related bloodstream infection, phlebitis, deep vein thrombosis, catheter occlusion, and catheter migration, dated 7/24/25. An intervention included: Measure external catheter length on admission, weekly, with each dressing change and prn (as needed). On 8/14/25 at 12:36 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #29's assessment of the measurements of the Midline catheter. The TAR with the lack of measurements was reviewed. The DON indicated that the measurements should be documented in the progress notes. The measurements in the progress notes for 7/31/25 of the external catheter measurement of 1 cm was reviewed with the DON, who indicated the measurement was possibly a typo. The DON was asked about facility policy on measurement assessments for Midline catheters. The DON reported the facility policy for Midline IV catheters was that dressing changes were completed on admission, within 24 hours on admission, and that the measurements would be completed during the dressing changes on admission and every seven days. The DON confirmed the lack of measurements with the dressing changes on 7/24 and 8/7 for Resident #29. An observation was made with the DON of Resident #29's Midline catheter to confirm the external catheter was greater than 1 cm.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent significant medication errors for two (2) resident (Resident #29 and Resident #58) of five (5) residents reviewed for medication errors resulting in potential for serious adverse effects for delayed medication without physician notification of the delay in medication as prescribed and potential for decline or worsening of medical condition.FacilityBased on observation, interview and record review the facility failed to prevent significant medication errors for two (2) resident (Resident #29 and Resident #58) of five (5) residents reviewed for medication errors resulting in potential for serious adverse effects for delayed medication without physician notification of the delay in medication as prescribed and potential for decline or worsening of medical condition. Findings include:Resident #29 (R29) R29 was [AGE] years old initially admitted on [DATE] with the diagnosis of Type 2 Diabetes Mellitus with foot ulcer, Other Cerebral Infarction due to occlusion or stenosis of small artery, atherosclerotic heart disease of Native Coronary Artery Without Angina Pectoris, and Essential Hypertension in addition to other diagnoses. R29, during Medication Administration, was in the hallway of the [NAME] Wing Nursing Station when he asked if his meds would be given after his therapy so he wouldn't be tired during the therapy session. RN K said okay and went on to the following resident. The following seven (7) medications were held without notifying the Provider MD:R29 Bag 1 contained:Acidophilus Cap 500 mg (Probiotic) in addition to other diagnoses.Aspirin EC Tab 81 mg 1 tab (minor aches and pains)Carvedilol (Coreg)Tab 3.125 mg (Alpha and beta-blocker to treat serious heart and blood vessel conditions)Clopidogrel (Plavix) Tab 75 mg (antiplatelet conditions to prevent blood clot formation)R29 Bag 2 contained:Entresto Tab 24/26 mg (Use to treat chronic heart failure)Jardiance 1 tab (Type 2 diabetes treatment)Vitamin D3 Cap 5000U (1225 MCG) X 2 capsules (for bones and calcium absorption) On 8/13/25 at 10:45 AM. A follow-up with the RN K revealed that she had administered R29's pills at around 10:30 AM. She admitted it was a late med pass. RN K was asked if the doctor was informed about the late medication, and RN K said No. Later in the afternoon on 8/13/25 at 3:00 PM, RN K was asked if she had notified the doctor or had noted the late medication administration in R29's clinical record. She said, I did not have time to do that yet, but I will definitely inform the physician about the Resident's 8:00 AM medication.The nurse held seven (7) medications without a physician's notification of the delay. The nurse did not explain the consequences if the due medications are held to the resident (R29). R29's seven (7) oral medications were reviewed, including heart medications and blood thinners, scheduled at 8:00 AM. The surveyor was informed that all medications due at 8:00 AM were given by RN K at approximately 10:30 AM. The delay in medication observation was discussed with RN K, who administered medication late on 8/13/25 at 10:30 PM. The DON and Administrator were notified at 3:30 PM, thereafter, regarding the error.Upon data entry, the medication error calculation was 36% over 25 observations. On 8/14/25 at 9:20 AM, policies were asked regarding medication administration and the PICC line care policy, which is to administer Antibiotics and flush after . In addition to a 36% Medication Error that was established on 8/13/25 at 10:30 AM, another late medication administration incident was observed in the [NAME] Wing Nursing Station the following morning on 8/14/25 at 10:30 AM. On 08/14/2025 at 10:23 AM, Nurse L, The [NAME] Wing's Medication cart computer screen had a lot of reds colored boxes. When Nurse L was asked what the red shaded boxes mean, she revealed that It means the medication is 'overdue. Nurse L explained that R58's medication was not available from the Pharmacy and that she was running behind with passing R58's 8:00 AM medications. Nurse L furthermore stated, We have 22 Residents with just one nurse administering all their meds due to. Resident #58 (R58) According to a Review of R58 Face Sheet, R58 was admitted from a nearby hospital to the facility on 8/11/25, with the following diagnoses: Acute Renal Failure, Urinary Tract Infection (UTI), Metabolic Encephalopathy, Paroxysmal Atrial Fibrillation, Essential Hypertension, Gastro-esophageal Reflux Disease (GERD), and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Atherosclerotic Heart Disease in addition to other diagnoses.Seven (7) medications were shown in red on the computer screen, which said they were due by 8:00 AM, but were administered at 10:23 AM on 8/14/25. Nurse L denied calling the doctor for the late administration of R58, scheduled morning medication.Upon review of R58's list of noted medications, the following significant medications were delayed:Eliquis (Apixaban)Oral Tablet 2.5 mg was ordered to be given one tablet twice daily. Eliquis is an anticoagulant (blood thinner) used to prevent and treat dangerous blood clots.Coreg (Carvedilol)Oral Tablet 3.125 mg was ordered, one tablet twice daily. Coreg is an Alpha and Beta-blocker used to treat serious heart and blood vessel conditions. The facility's policies for Medication Pass Guidelines and Medication Error were requested and reviewed. Medication Pass Guidelines with a revised date of September 2023 indicated the following:Purpose:To assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each Resident by providing the administration of drugs in an accurate, safe, timely, and sanitary manner, and to systematically distribute medications to residents in accordance with state and federal guidelines.Physician's Orders: Medications are administered in accordance with orders of the attending physician.Procedure:.5. Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. The Policy for Medication Errors, with the release date of February 2023, was reviewed on 8/14/25 at 3:30 PM. It indicated,Policy:It is the policy of this facility to provide protections for the health, welfare, and rights of each Resident by ensuring residents receive care and services safely in an environment free of significant medication errors.Policy Explanation and Compliance Guidelines:The facility shall ensure that medications will be administered as follows:According to the physician's orders.Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines:Resident's condition.Drug category.Frequency of Error: If an error is occurring repeatedly, such as an omission of a resident's medication several times.