| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235283 | A. Building<br>B. Wing | 12/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Medilodge of East Lansing | 1843 N Hagadorn Road<br>East Lansing, MI 48823 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains To Intake # 2631073, 2666145, 2655825, 2666019 and 267649Based on observation, interview and record review the facility failed to provide showers/bathing on a routine basis to maintain cleanliness and hygiene for 2 residents (Resident #2 and Resident #12) of four reviewed.Findings include: Resident #2 (R2) According to the medical record, including The Minimum Data Set (MDS) dated [DATE], revealed R2 was [AGE] year-old female admitted to the facility on [DATE] diagnosis of chronic obstructive pulmonary disease and heart disease, bipolar and schizoaffective disorder. R2 scored 15 out of 15 (cognitively intact) on the Brief Interview Status for Mental (BIMS). On 12/01/2025 at 12:42 am, During an interview with R2 she reported she has not had a shower since 11/20/25. R2 stated this was not uncommon and despite multiple complaints made to nursing management the issue is ongoing. Review of R2's Shower records for November 2025 revealed R2 received a total of 3 showers for the entire month of November (11/3, 11/6 and 11/20.) There was one documented refusal on 11/14. On 12/02/25 at 10:55 AM during an interview with Certified Nursing Assistant (CNA) W reported the facility did not have CNA's specifically for showers and each CNA was responsible to for their own assignment. CNA W stated residents should be receiving a shower twice a week, when asked to elaborate on should CNA W stated sometimes she is scheduled to give two showers which was doable and other days shed be scheduled 15 showers, which was not possible. Resident #12 (R12) Review of the clinical record revealed Resident #12 (R12) was admitted to the facility on [DATE] with a readmission date of 11/18/2025. R12 had diagnoses that included angel-man syndrome, cerebral palsy, chronic respiratory failure and constipation. Review of the Minimum Data Set (MDS) with an assessment reference date of 8/31/25 R12 was coded as having no speech, long and short-term memory impairment with severely impaired daily decision-making skills.On 12/03/25 at 10:24 am during a phone interview with R12's mother/legal guardian CC it was reported that she and other family members visit on a very regular basis and that she had requested meetings on multiple occasions with the facility interdisciplinary team regarding care concerns including but not limited R12 not receiving showers. Review of the facility concern log did reveal R12's mother/legal guardian CC did file a grievance form with the facility on 11/24/25 regarding care concerns including but not limited to R12 not getting his scheduled shower and family having to assist to ensure it was done. Of note, the grievance from had no documented response by facility staff. Review of R12's shower sheet in October reflected a shower was provided on 10/16 and not again until 10/26, with no refusal in between. Review of November shower sheets reflected R12 received a shower on 11/2 but not again until 11/9 with no refusal in between those dates. On 12/03/25 at 9:10am during an interview with ADON G she reported all residents were scheduled to have a shower at least twice a week. When queried about R12 and R2, ADON G stated there was a meeting with R12's mother/guardian CC yesterday and everything was resolved and she could not account for why R12 did not get regularly scheduled showers. ADON G stated in the case of R2, that R2 often refused or will tell staff she would like her shower later. It was requested at this time that documentation be provided to regarding these refusals /postponements. ADON G stated there was no documentation to support this. |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake #'s 2677649 and 2666019.Based on observation, interview and record review, the facility failed to monitor and treat constipation for two of three residents reviewed (Resident #12 and # 15) resulting in hospitalization for Resident #12.Findings include:Resident #15 (R15)<br><br>Review of the medical record revealed R15 was admitted to the facility 02/07/2025 with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), tracheostomy, type 2 diabetes, obesity, ventilator dependence, congestive heart failure (CHF), dysphagia (difficulty swallowing), hypoglycemia (low blood sugar, bilateral hearing loss, obstructive and reflux uropathy (blockage that hinders urine flow), and stage 3 kidney disease. R15's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/2025, revealed R15 did not have a Brief Interview for Mental Status (BIMS) completed during the MDS look back period.<br><br>Review of R15's medical record revealed the following bowel pattern: 10/14/2025- no bowel movement, 10/15/2025-no bowel movement, 10/16/2025-no bowel movement, 10/17/2025- no bowel movement, 10/18/2025- no bowel movement, 10/19/2025-no bowel movement. Review of R15's Medication Administration Record (MAR) for October 2025, revealed R15 was given Milk of Magnesia Suspension 400mg (milligrams)/5ml (milliliters) Give 30ml as need for constipation, was given on 10/19/2025. R15's record revealed he had medium bowel movement on 10/20/2025.<br><br>During an interview on 12/04/2025 at 10:04 a.m. Assistant Director of Nursing (ADON) G explained that resident bowel movements are monitored by the nursing staff, which are reported on the clinical dashboards on the computerized medical record. ADON G explained that when resident's do not have bowel movements in 3 days, the physician would be contacted to request mediation that would alleviate constipation. ADON G agreed that R15's medical record revealed he did not have a bowel movement between the dates of 10/16/2025 and 10/19/2025. ADON G could not explain why medication had not been given, prior to 10/19/2025, for R15's constipation.<br><br>During observation and attempted interview on 12/8/2025 at 08:30 a.m. R15 was observed lying in bed. R15 was unable to answer questions regarding constipation.<br><br>Review of the clinical record revealed Resident #12 (R12) was admitted to the facility on [DATE] with a readmission date of 11/18/2025. R12 had diagnoses that included angel-man syndrome, cerebral palsy, chronic respiratory failure and constipation. Review of the Minimum Data Set (MDS) with an assessment reference date of 8/31/25 revealed R12 was coded as having no speech, long and short-term memory impairment with severely impaired daily decision-making skills.<br><br>Review of R12's bowel elimination record for October 2025 revealed R12 had no record of having a bowel movement (BM) from 10/08/25 to 10/18/25, no BM 10/21, 10/22, 10/23, 10/24 and 10/25/25. The October Medication Administration Record (MAR) revealed the only intervention was on 10/19/25 when a suppository was administered, of note, the October MAR further revealed the suppository was ineffective. There was no record of R12 having a BM 10/29, 10/30 10/31, 11/1, 11/2, 11/3 and 11/4. No BM documented 11/08, 11/09, 11/10, 11/12, 11/13/25. Review of the medication administration record revealed a suppository was administered to R12 on 11/11 with unknown results and again on 11/13/25, in which R12 was transferred to the hospital.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Respiratory Therapy progress notes dated 11/13/25 at 06:50 AM revealed He was found to have dry vomit on his mouth/face to the left side of him, on his shirt and sheets underneath. There was a moderate amount of white, completely dry vomit. He was off the Ventilator. He had a HME (Heat Moisture Exchange) in place, on room air. HME had vomit in it. He appeared diaphoretic and pale with increased Work of Breathing (WOB.) He was non-responsive to all stimuli, including sternal rub. Extremities are cold. SpO2 (peripheral oxygen saturation- the percentage of oxygen carrying hemoglobin in the blood, indicating how well the lungs are oxygenating your body.) difficult to obtain. Once obtained SpO2 found to be 79%, HR (Heart Rate)110 bpm (Beats Per Minute). Immediately Resident was placed on Ventilator, cuff inflated to Micro laryngeal Tube (MLT.) No improvement in saturation or presentation. Oxygen bled into Ventilator. Titrated up to obtain saturation over 90%. Unable to obtain SpO2 of greater than 90% on Ventilator with 15 lpm (liters per minute) through Ventilator. IP (Inspiratory Pressure) increased to obtain better tidal volumes. No improvement. Began to bag with MVB (Mask Valve Bag). Able to achieve SpO2 of 95% with bagging at 15 lpm. Continued bagging for about 5 minutes to aide in recovery, then attempted to place back on the Ventilator. Placed on Ventilator with initially 15 lpm bled in, SpO2 was 94%. Attempted to wean oxygen to 12 lpm and SpO2 began to drop instantly. On call doctor contacted and EMS called. EMS arrived and began asking about Resident's code status.<br><br>Review of Nursing progress notes dated 11/13/25 at 07:06 AM, desaturation 75% on Room Air (RA) old vomit on shirt. Record checked for BM, last one was 11/7. Res (sic) placed on 02(oxygen) and recovered The progress note further revealed the physician was notified, a suppository was administered, 911 called and R12 was transferred to the hospital. Nursing notes dated 11/13/25 at 10:53 revealed the Nurse received an update from R12's family member who was at the hospital with R12 and stated suppository was effective.<br><br>Review of the hospital summary dated 11/13/25 revealed R12 . had a vomiting episode at the facility after which he was noted to have respiratory arrest and was bagged, EMS called and the patient was placed on a ventilator in the emergency department, a cat scan showed bilateral dense consolidation, possible 2 person witnessed aspiration event.<br><br>Review of the Infectious Disease Physician hospital notes dated 11/13/25 reflected R12 was presented to the hospital via EMS Found covered in vomitus, likely had aspiration event' .Thick mucus with milky tube feed was appreciated throughout airway. Bronchial wash was performed.<br><br>Review of hospital records 11/14/25 revealed R25 .for some reason removed from his vent around 3:00am and was found with emesis all over him this morning and respiratory arrest. Hospital progress notes dated 11/15/25 revealed constipation, a cat scan revealed an extended abdomen, and the plan was to increase bowel regimen and that R12 had aspiration pneumonia. Nutrition was administered via a nasal gastric tube opposed to the Percutaneous Endoscopic Gastrostomy (PEG) tube that R12 normally received nutrition due to R12's constipation.<br><br>Review of the hospital Registered Dietician (RD) progress notes dated 11/17/25 revealed R12's had less than optimal enteral nutrition related to tube feeding was on hold due to aspiration event as evidenced by constipation with unknown adherence to bowel regimen. The note additionally reported upon admission imaging R12's abdomen had been distended.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/03/25 at 10:24 am during a phone interview with R12's mother/legal guardian CC it was reported that she and other family members visited on a very regular basis and that she had requested meeting on multiple occasions regarding care concerns including but not limited to R12's constipation. Review of the facility concern log reflected R12's mother/legal guardian filed a grievance with the facility dated 11/06/25 that she was concerned with R12's lack of BM's and she was informed by the nurse on 11/6 that R12's last BM was 10/28. The concern form was assigned to Assisted Director of Nursing (ADON) G. Of note, the concern form section Findings and Plan/actions were blank the section Resolved and Results reported to were all left blank. The sections for signatures were blank.<br><br>On 12/03/25 at 9:10am during an interview with ADON G she reported she had a meeting with R12's mother/guardian CC yesterday and everything was resolved. When queried about R12's lack of bowel elimination and hospitalization for acute respiratory failure and aspiration pneumonia, ADON G reported R12's family was very involved and possibly changed R12 and didn't notify staff. When queried who was responsible for monitoring bowel records, ADON G stated it was the floor nurse's responsibility and the computer system will alert them if there is no BM for 3 days. When queried why there was no intervention, including the blank response to the grievance form filed on 11/6/25. ADON G stated the floor nurses may have cleared the alert without acting on it.<br><br>On 12/03/25 at 3:30pm, during an interview with the Director of Nursing (DON) B she reported the facility has no policy or procedure of bowel elimination or constipation, and that it was up to the Physician to act upon individual episodes of constipation. When quired how the Physician would be informed for someone like R12 who was unable to communicate their needs, DON B stated the Unit Manager and ADON G was responsible for tracking BM and notifying the Physician when an issue arises. DON B stated she would expect Unit Managers and the ADON G to notify the Physician after 3 days of no bowel elimination. DON B stated the family was involved and may not have told staff if R12 had a BM. When queried if the nurses get an alert of no BM, and the family is actively involved and, in the facility, would the expectation be that the Nurse ask the family prior to clearing the computer-generated alert? DON B stated that ADON G was working with the family on some issues including bowel elimination. |

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| F 0692<br>Level of Harm - Actual harm<br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | This citation pertains to intact 2655825Based on observation, interview, and record review the facility failed to prevent significant weight loss in two residents (#12, #16) of three residents reviewed for weight loss. Findings Included: Resident #12 (R12)Review of the medical record revealed R12 was admitted to the facility 05/24/2024 with diagnoses that included chronic respiratory failure with hypoxia, moderate protein calorie malnutrition, Angelman Syndrome (rare genetic disorder affecting the nervous system), gastrostomy, spastic quadriplegic (paralysis affecting both arms and both legs) cerebral palsy (brain damage during development), convulsion, dependence on respiratory ventilator, hypokalemia (low potassium), hypotension, esophagitis (inflammation esophagus), obstructive and reflux uropathy (blockage in urinary tract), pain, anxiety, anemia (low red blood cells) , and tracheostomy. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/31/2025, revealed R12 had a Brief Interview for Mental Status (BIMS) that could not be assessed as R12 is rarely/never understood.During observation and attempted interview on 12/03/2025 at 11:22 a.m. R12 was observed lying on a mattress on the floor. R12 did not respond to verbal questions. Review of R12's medical record revealed a Dietary Progress Note (dated 03/07/2025) that stated, Resident very active at night, crawls around on the floor and chewing on tubing, causing nursing to have to disconnect him from his TF (tube feeding). Wt (weight) change: triggered for sig (significant) wt. loss of 10.1% (13.7#) in six months.Review of R12's tubing feeding orders, with a start date of 2/14/2025, stated Two times per day. 2cal HN at 66ml(milliliters)/hr(hour) x 12 hr (hours), 792ml. Total volume 1583 Kcal. Review of March 2025 medication record revealed that R12's 04:00 a.m. dose of tube feeding was not given on dates of 03/04/2025 and 03/19/2025. The same March medication record revealed R12's 04:00 p.m. feeding tube was not given on 03/15/2025 and 3/16/2025. Review of the same March medication record revealed that R16's 04:00 a.m. dose only had 500ml out of 792ml of tube feeding solution on 03/04/2025, 03/05/2025, 03/06/2025, 03/07/2025, 03/08/2025, 03/09/2025, 03/10/2025, 03/11/2025, 03/12/2025, 03/13/2025, 03/14/2025, 03/15/2025, 03/16/2025, 03/17/2025, 03/18/2025, 03/20/2025, 03/21/2025, 03/22/2025, 03/23/2025, 03/24/2025, 03/25/2025, 03/26/2025, 03/27/2025, 03/28/2025, 03/29/2025, 03/30/2025, 03/31/2025. Review of April Medication record revealed R12 only received 500ml out of 792 ml of tube feeding solution, during 04:00 a.m. administration for the dates of 04/01/2025, 04/02/2025, 04/03/2025, and 04/04/2025.Review of R12's weight history revealed a weight of 142. 6 lbs (pounds) on 12/02/2024 and a weight of 111.5 lbs. on 04/24/2025. R12's weight had decreased by 31.1 lbs. in four months. During an interview 12/03/2025 at 01:58 p.m. Registered Dietician (RD) O explained that she had entered the progress note in R12's medical record that stated Resident very active at night, crawls around on the floor and chewing on tubing, causing nursing to have to disconnect him from his TF (tube feeding). Wt (weight) change: triggered for sig (significant) wt. loss of 10.1% (13.7#) in six months. RD O explained that she had reported this information to the Director of Nursing. RD O reviewed R12's medication record for March and April of 2025 and agreed that R12 had not received the prescribed caloric intact from his tube feeding. RD O explained the physician order, for the date of 04/04/2025 to 04/17/2025, was 2Cal HN @ 66mL(milliliters) /hr(hour) x 9hrs, 594mL total volume (1188kcal(kilocal), 49.5g protein, 416mL fluid) Auto flush @ 70mL/hr x 9hr, 630mL additional fluid run tube feed until total volume is given. RD O explained that a bolus order was supposed to be ordered also on 04/04/2025, so that R12 could receive his caloric needs of 1583 Kcal per day. RD O explained that from the date of 04/04/2025 until 04/17/2024 that R12 did not receive his required caloric intact. RD O could not explain why R12 did not received his caloric intact during the dates listed above. During an interview on 12/03/2025 at 03:22 p.m. Director of Nursing (DON) B explained that she had been made aware by RD O of the nursing staff not providing the appropriate tube feeding volume to R12 in March 2024. DON B could not provide any corrective action that had been taken following the incident for which R12 had not received the appropriate caloric intact. Resident #16 (R16) Review of the medical record revealed R16 was admitted to the facility 08/25/2025 with diagnoses that included cerebral infarction (stroke), type 2 diabetes, atrial fibrillation, pain, congestive heart failure (CHF), hypertension, anemia (low red blood cells), dysphagia (difficulty swallowing), and hyperlipidemia (high fat content in blood). Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 99 (interview could not be completed) out of 15. During observation and attempted interview on 12/03/2025 at 08:20 a.m. R16 was observed lying down in bed. Resident did not respond to verbal questions. Review of R16's medical record revealed that her weight on 09/05/2025 was 113.2 lbs. (pounds) |

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| F 0693<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | This citation pertains to intact 2655825Based on observation, interview, and record review the facility failed to follow physician orders for the administration of tube feeding solution for one resident (#12) out of three residents reviewed resulting in the harm of significant weight loss. Findings Included: Resident #12 (R12)Review of the medical record revealed R12 was admitted to the facility 05/24/2024 with diagnoses that included chronic respiratory failure with hypoxia, moderate protein calorie malnutrition, Angelman Syndrome (rare genetic disorder affecting the nervous system), gastrostomy, spastic quadriplegic (paralysis affecting both arms and both legs) cerebral palsy (brain damage during development), convulsion, dependence on respiratory ventilator, hypokalemia (low potassium), hypotension, esophagitis (inflammation esophagus), obstructive and reflux uropathy (blockage in urinary tract), pain, anxiety, anemia (low red blood cells) , and tracheostomy. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/31/2025, revealed R12 had a Brief Interview for Mental Status (BIMS) that could not be assessed as R12 is rarely/never understood.During observation and attempted interview on 12/03/2025 at 11:22 a.m. R12 was observed lying on a mattress on the floor. R12 did not respond to verbal questions. Review of R12's medical record revealed a Dietary Progress Note (dated 03/07/2025) that stated, Resident very active at night, crawls around on the floor and chewing on tubing, causing nursing to have to disconnect him from his TF (tube feeding). Wt (weight) change: triggered for sig (significant) wt. loss of 10.1% (13.7#) in six months.Review of R12's tubing feeding orders, with a start date of 2/14/2025, stated Two times per day. 2cal HN at 66ml(milliliters)/hr(hour) x 12 hr (hours), 792ml. Total volume 1583 Kcal. Review of March 2025 medication record revealed that R12's 04:00 a.m. dose of tube feeding was not given on dates of 03/04/2025 and 03/19/2025. The same March medication record revealed R12's 04:00 p.m. feeding tube was not given on 03/15/2025 and 3/16/2025. Review of the same March medication record revealed that R16's 04:00 a.m. dose only had 500ml out of 792ml of tube feeding solution on 03/04/2025, 03/05/2025, 03/06/2025, 03/07/2025, 03/08/2025, 03/09/2025, 03/10/2025, 03/11/2025, 03/12/2025, 03/13/2025, 03/14/2025, 03/15/2025, 03/16/2025, 03/17/2025, 03/18/2025, 03/20/2025, 03/21/2025, 03/22/2025, 03/23/2025, 03/24/2025, 03/25/2025, 03/26/2025, 03/27/2025, 03/28/2025, 03/29/2025, 03/30/2025, 03/31/2025. Review of April Medication record revealed R12 only received 500ml out of 792 ml of tube feeding solution, during 04:00 a.m. administration for the dates of 04/01/2025, 04/02/2025, 04/03/2025, and 04/04/2025.Review of R12's weight history revealed a weight of 142. 6 lbs (pounds) on 12/02/2024 and a weight of 111.5 lbs. on 04/24/2025. R12's weight had decreased by 31.1 lbs. in four months. During an interview 12/03/2025 at 01:58 p.m. Registered Dietician (RD) O explained that she had entered the progress note in R12's medical record that stated Resident very active at night, crawls around on the floor and chewing on tubing, causing nursing to have to disconnect him from his TF (tube feeding). Wt (weight) change: triggered for sig (significant) wt. loss of 10.1% (13.7#) in six months. RD O explained that she had reported this information to the Director of Nursing. RD O reviewed R12's medication record for March and April of 2025 and agreed that R12 had not received the prescribed caloric intact from his tube feeding. RD O explained the physician order, for the date of 04/04/2025 to 04/17/2025, was 2Cal HN @ 66mL(milliliters) /hr(hour) x 9hrs, 594mL total volume (1188kcal(kilocal), 49.5g protein, 416mL fluid) Auto flush @ 70mL/hr x 9hr, 630mL additional fluid run tube feed until total volume is given. RD O explained that a bolus order was supposed to be ordered also on 04/04/2025, so that R12 could receive his caloric needs of 1583 Kcal per day. RD O explained that from the date of 04/04/2025 until 04/17/2024 that R12 did not receive his required caloric intact. RD O could not explain why R12 did not received his caloric intact during the dates listed above. During an interview on 12/03/2025 at 03:22 p.m. Director of Nursing (DON) B explained that she had been made aware by RD O of the nursing staff not providing the appropriate tube feeding volume to R12 in March 2024. DON B could not provide any corrective action that had been taken following the incident for which R12 had not received the appropriate caloric intact. |

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|---|---|---|---|
| | 235283 | A. Building<br>B. Wing | 12/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Medilodge of East Lansing | 1843 N Hagadorn Road<br>East Lansing, MI 48823 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake #2627443, 2634124, 2642694, 2662031, 2668275. Based on observation, interview and record review the facility failed to ensure sufficient nursing staff and call lights were responded to in a timely manner for 3 of 3 residents reviewed (Resident #2, Resident #4 and Resident #7). Resident #4 (R4):<br><br>Review of the medical record revealed R4 was admitted to the facility 10/28/29 with diagnoses that included quadriplegia, chronic respiratory failure, neuromuscular dysfunction of bladder (nerve damage of the bladder), sever protein calorie malnutrition, tracheostomy, colostomy, iron deficiency, stage 3 pressure ulcer, asthma, and insomnia. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/27/2025, revealed R4 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. R4 was discharged to the hospital 11/30/2025<br><br>R4 was unable to be interviewed as he was admitted to the hospital. According to his complaint intake, the facility is not staffed adequately to provide sufficient care to meet the needs of the residents.<br><br>During an interview on 12/02/2025 at 11:55 a.m. the Nursing Scheduler (NS) K explained that she was responsible for the daily Nurse staffing. She explained that she staffs each shift and unit according to a staffing grid, which is determined by the census in the facility. Staffing sheets were reviewed in cooperation with NS K and were found not to have enough nursing staff according to the facilities staffing grid:<br><br>- 10/4/2025- (census 71) CNA-15 staffed. There should have been 18. 3 short on 1st shift .<br><br>-10/11/2025-(census 74) CNA - 5 during the day shift. There should have been 6.<br><br>-10/12/2025- (census 74) CNA-17 staffed. There should have been 19. 2 short on the 3rd shift.<br><br>-10/17/2025- (census 70) CNA-15. Should have been 17.5. Short 1.5 on the 2nd shift and 1 short on the 3rd shift.<br><br>-10/19/2025 (census 72) CNA-16. Should have been 19. Short 1 on the 1st shift and 2 short on the 3rd shift.<br><br>-10/20/2025 (census 72) Nurses 8. should have been 9, 1 nurse short. CNA-17 should have been 18. Short 1 on 1st shift.<br><br>- 10/21/2025 (census 74) CNA-16. Should have been 19. One short on 1st shift and two short on 2nd shift.<br><br>-10/25/2025 (census 76) CNA-14. Should have been 19. 3 short on 1st shift, 2 short on 2nd shift.<br><br>-10/26/2025 (census 76) CNAs-16. Should have been 18. 1 short on 1st shift, 1 short on 3rd shift.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -11/01/2025 (census 76) CNA- 17. Should have been 19. 2 short on 1st shift.<br><br>- 11/03/2025 (census 76) CNA 18. Should have been 19. 1 short on 2nd shift.<br><br>-11/04/2025 (census 74) Nurses 8. Should have been 9. 1 nurse short on first shift. CNA 18. Should have been 19. 1 short on 2nd shift.<br><br>-11/08/2025 (census 78) CNA- 15. Should have been 20. 3 short on 1st shift and 2 short on 3rd shift.<br><br>-11/10/2025 (census 78) CNA 18. Should have been 20. 2 short 2nd shift.<br><br>- 11/12/2025 (census 80) Nurses 9. Should have been 10. 1 short on 1st shift.<br><br>Resident #2 (R2)<br><br>According to the medical record, including The Minimum Data Set (MDS) dated [DATE], revealed R2 was [AGE] year-old female admitted to the facility on [DATE] diagnosis of chronic obstructive pulmonary disease and heart disease, bipolar and schizoaffective disorder. R2 scored 15 out of 15 (cognitively intact) on the Brief Interview Status for Mental (BIMS).<br><br>On 12/01/2025 at 12:42 am, During an interview with R2 it was reported she has not had a shower since 11/20/25, does not get assistance timely she stated she often waits for an hour to have her call light answered and frequently staff will come in her room, turn the call light off and tell her they will be back momentarily but don't come back. R2 elaborated this was common occurrence, stating she had complained to nursing management staff many times, and it was brought up by others in Resident Council, but nobody takes the concern serious.<br><br>Resident #7 (R7)<br><br>R#7 was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of quadriplegia. Review of the Minimum Data Set (MDS) dated [DATE], revealed R7 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS).<br><br>On 12/02/25 at 12:53 pm, during a bedside interview R7 reported the facility was perpetually understaffed. R7 stated he has filed multiple grievances with the facility about staffing and call light response time but nothing changes. R7 reported he was hungry a few evenings ago and requested a bowl of cereal but was told by his nursing assistant No when quired why he couldn't get cereal R7 stated he was told that because he requires staff to feed him, they did not have time.<br><br>Review of Resident Council Meeting minutes dated 10/14/25 revealed a concern with call light response time under old business, however when the 09/02/25 Resident Council Meeting minutes were reviewed, the mention of call light response time was mentioned under old business. It was requested to review the concern form generated from the Resident Council meetings as it pertained to call light response times.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/03/25 at 2:15 pm, during an interview with Regional Nurse Consultant DD she reported the facility was unable to locate concern forms related to the Resident Councils concerns related to staffing levels or call light response time identified in the Resident Council Meeting minutes.<br><br>In an observation on 12/8/2025 at 9:46 AM, it was observed that three call lights were going off in the long-term care hall. Four staff members were observed to not respond to the call light, two of the staff members were sitting at the nurse's station where the call light buzz was audible and did not respond. Director of Nursing (DON) B entered the hall, approached the nurse's medication cart, spoke with the nurse, but did not respond to the call lights that were buzzing. At 9:48 AM a nurse was observed to be sitting at the nurse's station but still did not respond to call light. By 9:49 AM only one call light was on, staff were observed in the hall and at the nurse's' station, however, no one responded to the call light.<br><br>It was observed on 12/8/25 at 9:56 AM that two call lights were buzzing and two nurses, one at the desk and one at the cart, did not respond to the call lights.<br><br>On 12/8/2025 at 10:12 AM, one call light was observed to be on, and four staff members were observed to be at the nurse's station. None of the four staff members responded to the call light. At 10:13 AM a staff member was observed to go to the room across from room [ROOM NUMBER], which was the room that had the call light on, the staff member spoke briefly with the resident and then left without responding to the call light that was going off in room [ROOM NUMBER]. At 10:14 AM the call light in room [ROOM NUMBER] continued to buzz. Three staff members were observed at the nurse's station and none of the three staff members responded to the call light. At 10:16 one staff member was observed to be in the hall but did not respond to the call light in room [ROOM NUMBER]. Another two staff members were observed to be standing at the nurse's station, did not respond to the call light, but rather walked away and out of the unit. At 10:18 AM the Unit Manager as observed to walk by the nurse's station where the call light was audible and did not address the call light.<br><br>In an interview with Director of Nursing (DON) B on 12/8/2025 at 10:25 AM, DON B stated that her expectation was that all staff, anyone, was to answer a call light, and stated that if the person who answered the call light was not able to assist the resident then the call light was to be left on and the nurse was to be made aware of the resident's need.<br><br>Review of the facility's policy and procedure titled, Call Lights: Accessibility and Timely Response dated 10/19/2020, revealed under Policy Explanation and Compliance Guidelines, 7. Any staff member who sees or hears an activated call light is responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper storage of medication, medications observed in hall unattended, for one resident (#18) out of a facility census of 68 residents. Findings Included:Resident #18 (R18)Review of the medical record revealed R18 was admitted to the facility 07/22/2024 with diagnoses that included stroke, hypertension, chronic pain, bradycardia, bilateral hearing loss, dementia, post-traumatic stress disorder, prostate cancer, gastro-esophageal reflux disease, adjustment disorder with depressed mood, constipation, and restless leg syndrome. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/25, revealed R18 had a Brief Interview for Mental Status (BIMS) of 10 (moderate cognitive impairment) out of 15. During the initial tour of the facility on 12/01/2025 at 09:14 a.m. a medication cup, with medication, was observed sitting on top of an isolation care outside room [ROOM NUMBER]. No staff were in the vicinity of the medication, and no residents were in the vicinity of the medication. Regional Director of Respiratory Therapy T was observed collection the medication cup. The medication cup was observed to contain 3 round pills, 2 oblong pills, 1 capsule, and one bottle of nasal spray. Regional Director of Respiratory Therapy T explained that she would take the medication to the Director of Nursing B. The facility identified that the medication belonged to R18. The medication in the medication cup was identified as one tablet multivitamin with minerals, one tablet vitamin D 1000 units, one tablet donepezil HCL (hydrochloride) 10 mg (milligrams), one tablet memantine HLC 10 mg, one tablet proton 40mg, one capsule fluoxetine 20mg and one bottle of fluticasone propionate suspension 50 MCG (micrograms).During observation and interview on 12/01/2025 at11:27 a.m. R18 was observed sitting in his wheelchair in the dining room. R18 could not verify that the nursing staff had given him his medication this morning. During an interview on 12/08/2025 Director of Nursing (DON) B explained that it was facility policy that during medication administration, medication must be under the direct observation of the person administering the medications. DON B explained that on 12/01/2025 she was made aware of medication that was left unattended. DON B explained that she had identified that the medication belonged to R18. DON B explained the medication was destroyed. DON B explained that R18's medication was re-pulled from the medication cart and distributed to R18. Review of facility policy entitled Medication Storage, with an implementation date of 10/30/2020 and last review date of 01/03/2024 revealed Policy Explanation and Compliance Guidelines- 1. General Guidelines: c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. |