STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an appropriate call button was provided for use and placed within reach of one resident (R74) of one resident reviewed for accommodation of needsFindings include:On 3/16/2026 at approximately 8:42 a.m., R74 was observed in their room, laying in their bed. R74 was asked if they had any concerns with the care and they reported they wanted their bed raised up. R74 was asked if they could use the call button to call for help and they reported they could not find it. R74's call button was observed to be unclipped and hanging off the site of the bed on the floor. R74 was asked if they had the ability to use the call button and they reported they did not think so because they had trouble with their hands. R74 was asked how they get help from staff and they reported the did not know. On 3/16/26 at approximately 3:11 p.m., R74 was observed in their room, laying in their bed. R74 was queried if they had the ability to use their call button and they reported they did not. R74 was queried how they call for assistance from facility staff, and they indicated they have to yell out for help, but sometimes nobody will hear them if they are not walking by. On 3/17/26 at approximately 1:07 p.m., R74 was observed in their room, sitting in their wheelchair. R74 was asked if they knew where their call button was located and they indicated they did not as they do not see well. R74 was queried if they could reach their call light and they indicated they could not. R74's call light was observed on their bed, out of reach and inaccessible to R74. On 3/18/26 at approximately 8:50 a.m., R74 was observed in their room, lying in their bed. R74's call light was observed to be up on the side of the bed located up by R74's neck out of reach of R74's hands/arms. R74 was queried if they could reach their call button and they indicated they could not. R74 was queried if they could use their call button if they had it by pressing down on it and they indicated they could not because they have a problem with their hands. R74 was asked if they felt they could use a touch pad that only required laying their hand on the pad, instead of wrapping their hand around it and pressing down and they indicated it would be better for them. On 3/16/26 the medical record for R74 was reviewed and revealed the following: R74 was initially admitted to the facility on [DATE] and had diagnoses including osteoarthritis and quadriplegic cerebral palsy. A review of R74's MDS (minimum data set) with an ARD (assessment reference date) of 2/9/26 revealed R46 was dependent on staff with most of their activities of daily living. A review of R74's care plan revealed the following: I have an ADL (activities of daily living) self-care performance deficit related to weakness, CP (Cerebral Palsy) with quadriplegia and OP (osteoporosis). Date Initiated: 02/03/2026 On 3/18/26 at approximately 9:05 a.m., Nurse Manager U (NM U) was observed assessing R74's ability to use their call button. R74 reported they were not able to use it and was unsuccessful in demonstrating their ability to press the button to call for assistance. NM U reported they would provide R74 a touch pad to call for assistance that did not require R74's hands to wrap around and press down. NM U reported that a bell may also work, but R74 was unable to use the current call button. NM U was queried if the call button should be place within the reach of residents for use and they indicated that it should be. NM U was queried how staff assess for ability to use the light and they reported that it was an observation made by CNA's and Nurses if they could use it or not. On 3/18/26 a facility document titled Call Light as reviewed and (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the following: PROCEDURE PURPOSE: To respond promptly to resident's call for assistance .To assure call system is in proper working order. PROCEDURE DETAILS: 1. Facility personnel must be aware of call lights. 2. Answer call lights in a prompt, calm, courteous manner. 3. You must turn the call light off at the point of origin; this is accomplished by pushing the switch or by depressing the ring around the button that activates the call light. 4. When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light. 5. Orient new residents to the call light system. 6. Notify the maintenance department and enter defective call light location(s) in the TELS system. 7. Place call light on the bed or preferred location stated by the resident prior to leaving the room .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a safe, homelike environment for one (R71) of four residents reviewed for the environment. Findings include:On 3/16/26 at 8:56 AM, R71 was observed lying in bed. R71 was asked if she had any concerns about the facility. R71 explained she was worried that the [NAME] attached above the dresser was going to fall and break all her items on the shelves. Observation of the shelves of the [NAME] revealed the pegs, that normally connect the shelf to the upright support, were completely visible and not attached to the upright support on the right side of the [NAME]. The back of the [NAME] was also not connected to the upright support and a gap of approximately 1 1/2 inches was observed on the bottom right-hand corner. Observation of the items on the shelves revealed various personal and decorative items, many would be broken if the [NAME] fell apart. R71 was asked if she had talked to anyone about the condition of the [NAME]. R71 explained she had talked to Maintenance approximately three weeks prior and was told it would be removed, but she had not heard anything else about it, and it was still there.Review of the clinical record revealed R71 was admitted into the facility on 3/21/24 with diagnoses that included: diabetes, heart disease and anxiety disorder. According to the Minimum Data Set [MDS] assessment dated [DATE], R71 had moderately impaired cognition.On 3/17/26 at 11:08 AM, the Maintenance Director [Staff ?A'] was interviewed and asked if he was aware of any concern with R71's [NAME] on the dresser. Staff ?A' explained he was not. Upon observation of the [NAME] with Staff ?A', Staff ?A' explained he would remove the [NAME] immediately. When asked how the shelves in the [NAME] were being supported, Staff ?A' explained there was a band behind the back, but the [NAME] needed to be taken down. Staff ?A' was asked if the condition of the [NAME] was something that he expected staff to report to him. Staff ?A' explained he would have expected staff to report something in that condition.On 3/17/26 at 12:32 PM, the Administrator and Director of Nursing [DON] were interviewed together. Both were asked who at the facility could report things that needed to be repaired to the Maintenance Department. The DON explained all staff members could report to the Maintenance Department. Review of a facility policy titled, Homelike Environment revised 5/2025 read in part, .Residents are provided with a safe, clean, comfortable and homelike environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one Resident (R8) of one resident reviewed for restraints had appropriate clinical justification/assessments for the use of a seatbelt. Findings include:On 3/17/26 at 2:56 PM, R8 was observed in the dining room sitting in their wheelchair playing bingo with other residents. After bingo was completed, R8 was asked about their seat belt and if they were able to unlatch it by themselves. R8 reported that they could not remove the belt themselves and when they were asked if they knew why they had the seat belt in place R8 replied with a gesture of a shoulder shrug.A review of the record revealed that R8 was admitted to the facility on [DATE] with the admitting diagnosis of Muscular dystrophy, Friedreich Ataxia and Mood disorder due to known physiological condition with depressive features. R8 has a Brief interview for [NAME] status score of 15 which indicated no cognitive impairment.On 3/17/26 at 9:37 AM, an interview was conducted with the Director of Nursing (DON) who was asked about the seat belt restraint for R8 and if their were consents, physician orders and appropriate documentation for the use of the seat belt. The DON reported that they did not have a consent because the mother of R8 requested that they use the seat belt for safety and poor trunk control. The DON was then asked if R8 required a seat belt? The DON reported that she knew that her seat belt broke but that would be a question for the Unit Manager.On 3/17/26 at 10:43 AM, Certified Nursing assistant (CNA) W was interviewed and reported that they were familiar with R8's care and had taken care of them before. CNA W was asked if R8 required a seat belt while up in the wheelchair. CNA W reported that R8 did require the use of a seatbelt only when they were in the wheelchair.A review of the medical record revealed that a medical order was placed on 3/17/26 which read . Seat belt released per facility policy. And a progress note written by the DON on 3/17/26 which read in part, Spoke to resident mother/legal guardian with unit manager regarding seatbelt in w/c (wheelchair) and she states she is fine with it and gives permission to use as she is the one that wanted seatbelt as her daughter has no trunk control and slides from chair and this is what keeps her safe.On 3/18/26 and interview with Unit Manager (UM) V was conducted. They were asked to provide the physician orders for the seat belt restraint prior to 3/17/26. UM V reported that they did not have an order, but they could show the point of care charting that the CNAs completed on the seatbelt. UM V was asked if there had been any training to the staff on how to use the seatbelt, the clinical justification for the device and what alternatives were tried before this device was put into place. UM V reported that they could not answer those questions because the seat belt was already in place when they began employment at the facility.On 3/18/26 at 9:23 AM, an interview with the DON was conducted. The DON was asked was the seatbelt for R8 considered a restraint. The DON reported that they did not consider the seatbelt a restraint if it was used for positioning since R8 doesn't have any trunk control and cannot control their movements and it (the seatbelt) was not affecting their daily life. The DON was asked what was the medical reasoning and the physician oversite on the use of the restraint. The DON reported that the seat belt was used for positioning and safety due to muscular dystrophy, she reported that she would have to look for physician documentation because it was applied two years ago. The DON was asked how often should R8 be reassessed for the use the restraint. The DON is reported annually and when there is a change in condition. The DON was asked about the last assessment in the medical record that was completed on 12/18/24 and the DON reported there were two assessments completed in the that same year. A review of the medical record revealed that the assessment tool completed on 12/18/24 read in part If resident has issues with balance while sitting and cannot recover balance under their own power, may want to consider a restraint if all other alternatives have been attempted. There was no additional information provided by the exit of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure enteral feeding was documented correctly and administered according to the Physician's order for one resident (R3) of one resident reviewed for enteral feeding. Findings include:On 3/16/26 at approximately 9:57 a.m., R3 was observed in their room, lying in bed. R3 was observed to have enteral formula infusing via their J-tube (jejunostomy) at 45 ml (milliliters) an hour. R3's Bottle of formula that was hanging on the pole contained no information on it including the name, rate and date/time bottle was hung. All of the documentation fields were observed to be blank. On 3/16/26 at approximately 3:23 p.m., R3 was observed in their room, laying in their bed. R3 was observed to have enteral formula infusing at 45 ml and hour with a total feed of 2293 indicated on the pump. R3's bottle of formula was observed with the 'rate field left blank. On 3/16/26 the medical record for R3 was reviewed and revealed the following: R3 was initially admitted to the facility on [DATE] and had diagnoses including Disorders of Bilirubin metabolism and Severe protein-calorie malnutrition. A review of R3's MDS (minimum data set) with an ARD (assessment reference date) of 2/27/26 revealed R3 needed assistance from facility staff with their activities of daily living. Section K indicated R3 had a feeding tube. A review of R3's care plans revealed the following Focus-I require a tube feeding Digestive Pancreatic Cancer: Gastric Outlet Obstruction Date Initiated: 02/11/2026 .Interventions-TF (tube feeding) per orders Date Initiated: 03/09/2026 . A Physician's order dated 3/6/26 revealed the following: two times a day Verify placement. Flush with 30mL of water. Start Pivot 1.5 at 1400/ 2 PM @ 40 ml/hr (hour) & continue until 800 mL/1200 kcal (kilocalories) have infused AND two times a day Use JT port for TF. Flush with_50___mLs water every _1_hours during pump infusion total 1000 ml. AND every night shift Ensure TF running during shift A Nutritional evaluation dated 3/6/26 revealed the following: Pivot 1.5 40 ml/hr (hour) x 20 hrs (hours) = 800 ml/1200 kcal, 75 g pro, 600 ml H2O (water) . On 3/16/26 at approximately 3:25 p.m., R3's enteral feeding order was reviewed in the EMR (electronic medical record) with Nurse X. Nurse X indicated they were unaware the order had been changed earlier the previous week and that they would go change the setting on the pump to the current active order of 40 ml's an hour. On 3/18/26 at approximately 9:40 a.m., Nurse Manager U (NM U) was queried regarding the multiple observations of R3's enteral feeding infusing at 45 ml outside of the Physician's orders and they indicated that R3's goal was to get to 45 ml's and hour but that the Nurse should be following the Physician's order. NM U was queried regarding the standard of practice regarding the documentation requirements for the bottle of formula that was hung on the pole and they indicated that the name, room number, date and rate should be on the bottle that was being used for the infusion. On 3/18/26 a facility document titled Enteral Nutrition was reviewed and revealed the following: Policy Statement-Adequate nutritional support through enteral nutrition is provided to residents as ordered.Policy Interpretation and Implementation1.The interdisciplinary team, including the dietitian, conducts a full nutritional assessment within current initial assessment timeframes to determine the clinical necessity of enteral feedings. The assessment includes: Evaluation of the resident's current clinical and nutritional status; Relevant functional and psychosocial factors; and A review of interventions to maintain oral intake prior to the use of a feeding tube and the resident's response to them. 2. The recommendation to initiate the use of enteral nutrition is based on the results of the comprehensive nutritional assessment, and is consistent with current standards of practice, the resident's advance directives, treatment goals and facility policies. 3. The dietitian, with input from the provider and nurse: Estimates calorie, protein, nutrient and fluid needs; Determines whether the resident's current intake is adequate to meet his or her nutritional needs; Recommends special food formulations; and Calculates fluids to be provided (beyond free fluids in formula).4. Enteral nutrition is ordered by the provider based on the recommendations of the dietitian. If a feeding (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tube is ordered, the provider and interdisciplinary team document why enteral nutrition is medically necessary.5. Some examples of potential benefits of using a feeding tube include: Addressing malnutrition and dehydration; Promoting wound healing; and/or Allowing a resident to gain strength that may allow him or her to return to oral nutrition. 6.If the resident has a feeding tube placed prior to admission or returning to the facility, the provider and the interdisciplinary team will review the rationale for the placement of the feeding tube, the resident's current clinical and nutritional status, and the treatment goals and wishes of the resident.7.The decision to continue or discontinue the use of the feeding tube is made through collaboration between the interdisciplinary team, the provider and the resident. 8.The dietitian monitors residents who are receiving enteral nutrition, and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings.9. The nursing staff and provider monitor the resident for signs and symptoms of inadequate nutrition, altered hydration, hypo- or hyperglycemia, and altered electrolytes. The nursing staff and provider also monitor the resident for worsening of conditions that place the resident at risk for the above.10. Enteral feedings are scheduled to try to optimize resident independence whenever possible (e.g., at night or during hours that do not interfere with the resident's ability to participate in facility activities).11.Complete orders include:The enteral nutrition product; Delivery site (tip placement);The specific enteral access device (nasogastric, gastric, jejunostomy tube, etc.; Administration method (continuous, bolus, intermittent); Volume and rate of administration; The volume/rate goals and recommendations for advancement toward these; and Instructions for flushing (volume, frequency, timing and 24-hour volume).12.The provider will consider the need for supplemental orders, including: Confirmation of tube placement; Laboratory monitoring;Instructions for EN preparation.Nutritional consultation; Head of bed elevation; Oral care; and Checks for gastric residual volume (GRV). 13. Staff caring for residents with feeding tubes are trained on potential adverse effects of tube feeding, such as: Reduced opportunity for socialization;Diminished sensory experience; and Restriction of movement.14. Staff caring for residents with feeding tubes are trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube, such as:Aspiration;Tube misplacement or migration; Skin breakdown around insertion site; Perforation of the stomach or small intestine leading to peritonitis; Esophageal swelling, strictures, fistulas; and Clogging of the tube.15.Staff caring for residents with feeding tubes are trained on how to recognize and report complications relating to the administration of enteral nutrition products, such as:Nausea, vomiting, diarrhea and abdominal cramping; Inadequate nutrition; Metabolic abnormalities; Interactions between feeding formula and medications; and Aspiration.16. Risk of aspiration is assessed by the nurse and provider and addressed in the individual care plan. Risk of aspiration may be affected by: Diminished level of consciousness; Moderate to severe swallowing difficulties; Improper positioning of the resident during feeding; and Failure to confirm placement of the feeding tube prior to initiating the feeding.17. Residents receiving enteral nutrition are periodically reassessed for the continued appropriateness and necessity of the feeding tube. Results of these assessments are documented, and any changes are made to the care plan. Input from the resident or legal representative is included in the assessment.18. Central supply is responsible for ordering all tube feeding supplies. The staff may use products from a basic formulary until any specialized products can be delivered .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure resident care equipment was in safe operating condition for one (R116) of four residents reviewed for environment concerns. Findings include:Multiple observations of R116's room were conducted from 3/16/26 - 3/17/26 which identified the following concerns:On 3/16/26 at 8:28 AM, 9:16 AM, 9:34 AM, 12:24 PM, and 3/17/26 at 7:55 AM and 11:10 AM, R116's footboard appeared to be broken and was tilted sideways and leaned down on the left side). Additionally, the low air mattress electrical panel which was secured to the footboard had a continuous flashing red light for the indicator labelled Power Fail.On 3/17/26 at 11:10 AM, the Maintenance Director (Staff ?A') was asked to observe R116's room. Upon entering the room, Nurse ?E' was standing next to the resident who was seated in a gerichair recliner obtaining vitals. The same flashing red light was observed on the air mattress unit and the footboard remained leaning down on the right side. When asked about the air mattress unit, Staff ?A' pressed a button on the unit and stated sometimes the unit had to be reset and they had power surges at times. When Nurse ?E' was asked if they had identified any concerns with the air mattress unit and footboard, they reported they did not but acknowledged the flashing light and leaning footboard.When asked if anyone had reported any similar concerns about that, Staff ?A' reported there were none. They further reported the facility utilized an electronic reporting system that all staff had access to, but there were none reported about R116's concerns with the air mattress or footboard. When informed of the multiple observations from 3/16 - 3/17/26 of the same flashing indicator and leaning footboard, Staff ?A' reported the expectation is that those should've been identified by staff and reported so they could've addressed it sooner. Staff ?A' proceeded to remove the footboard and reported the screws were broken and needed to be replaced.On 3/17/26 at 12:00 PM, an interview was conducted with the Administrator and Director of Nursing. At that time, they were informed of the observations and interview with staff regarding R116's air mattress unit and footboard. The Administrator reported staff had been in-serviced multiple times about reporting concerns when identified and would have to follow-up.According to the facility's policy titled, Quality of Life - Homelike Environment dated May 2017:Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .According to the facility's policy titled, ?Maintenance Service dated Revised 2009: .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.