STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235289	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Borgess Place	3057 Gull Road Kalamazoo, MI 49048

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a person-centered care plan for the prevention of pressure ulcers for 1 (Resident #47) of 18 residents reviewed for person centered care plans resulting in Resident #47 developing an open wound on his coccyx (tail bone area) and a pressure ulcer on his left heel.Findings include:Review of an admission Record revealed Resident #47 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: CVA (cerebral vascular accident/ stroke), hemiplegia of the left side (inability to move the left side of the body), peg-tube (percutaneous endoscopic gastrostomy tube- a tube inserted into the stomach to provide artificial nutrition) and aphasia (a disorder that affect show a person communicates).Review of a Minimum Data Set (MDS) assessment for Resident #47, with a reference date of 8/1/2025 revealed Section GG - Functional Abilities - Admission coding included self-care.code the resident's usual performance at the start of the stay for each activity . Mobility.Roll left and right, sit to lying, lying to sitting on the side of the bed, chair/bed-to-chair transfer, all areas Resident #47 was as 01-dependent.Section M - Skin Conditions - Determination of Pressure Ulcer/Injury Risk.Risk of Pressure Ulcer/Injuries. is this resident at risk of developing pressure ulcer/injuries? coded 1- Yes.Unhealed pressure ulcers/injuries.Does this resident have one or more unhealed pressure ulcers/injuries? Coded 0 - No.In an interview on 8/11/25 at 11:23 am, Family Member (FM) UU reported Resident #47 had been in the facility for almost 3 weeks and he now has multiple wounds. FM UU reported Resident #47 did not have any wounds when he admitted to the facility.Review of Braden Score (a standardized, evident-based assessment tool used in healthcare to assess a patient's risk for developing pressure injuries) for Resident #47 dated 7/26/25 at 3:04 pm revealed 12 High Risk.Review of Nursing Evaluation- Section Skin for Resident #47 dated 7/26/2025 at 17:06 (5:06 pm) revealed Resident #47 had no skin impairments on admission. Review of Care Plan for Resident #47 revealed Focus. the resident has limited physical mobility r/t weakness and CVA with left sided weakness. resident will remain free of complications related to immobility.skin-breakdown.interventions. provide supportive care, assistance with mobility as needed. Document assistance as needed.initiated on 7/26/2025.Focus. The resident has potential for impairment to skin integrity r/t recent CVA with left sided weakness, decreased mobility, and strength, MASD (moisture associated skin damage).Goal. The resident will remain free of new skin impairment.Monitor skin when providing care, notify nurse of any changes in skin appearance. initiated on 7/26/2025. There was no care planned preventative measures noted for Resident #47 with a Braden score of 12, high risk to prevent skin breakdown.In an interview on 8/11/25 at 11:53 am, FM UU reported the facility staff started repositioning Resident #47 off his bottom after the wound on his coccyx developed.Review of Care Management note for Resident #47 dated 7/30/2025 at 13:30 (1:30pm) revealed .Interdisciplinary Care Management Summary: .The IDT (interdisciplinary team) agrees with plan of care.In an interview on 8/13/2025 at 9:50 am, Wound Care Nurse/Registered Nurse (WCN/RN) S reported she was new to the wound nurse roll and her responsibilities were still being defined. WCN/RN S reported Resident #47 had care plan interventions (continued on next page)

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	in place such as floating heels on a pillow, turn every 2-3 hours, monitor wound weekly and take measurements and that she had initiated those interventions on 8/5/2025 when the wound was noted on his coccyx.In an interview on 8/13/2025 at 1:14 pm, LPN D reported she has never been shown anything related to care plans and she has never put one in place.Review of Care Plan for Resident #47 revealed .focus.The resident has an actual ADL self-care performance deficit r/t his impaired strength, mobility , left sided weakness.interventions: PRAFO boots when in bed date initiated 8/11/2025.PT/OT (physical therapy/occupational therapy) evaluate and treat.initiated 8/11/2025.Focus.The resident has potential for impairment to skin integrity r/t CVA with left sided weakness, decreased mobility and strength, impaired safety.MASD.Interventions: apply barrier cream per facility protocol to help protect skin from excess moisture.initiated 8/11/2025.change bedding/clothing if moist.initiated 8/11/2025.Air mattress as ordered.initiated 8/11/2025.elevate heels while resting is lying in bed with heel protectors as he allows. initiated 8/11/2025.Turn and reposition resident every 2-3 hours, use wedge cushion.initiated 8/11/2025.Focus The resident has actual impairment to skin integrity MASD to coccyx and right buttock.initiated 8/5/2025.Goal. Resident's skin integrity will improve.initiated on 8/5/2025. Interventions. Educate resident/family caregiver of causative factors and measures to prevent skin injury. initiated 8/5/2025.ensure resident has bilateral (both feet) heel protecting boots on at all times as resident allows. initiated 8/5/2025. Keep skin clean and dry. Try to reduce as much moisture as possible 8/5/2025.turn and reposition eve3ry 2-3 hours and PRN (as needed). initiated 8/5/2025.Use a draw sheet or lifting device to move resident. initiated on 8/5/2025. Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudated (drainage) and any other notable changes or observations initiated on 8/5/2025.Focus. Resident has condom catheter size large. the resident will show no s/sx (signs and symptoms) of urinary infection. initiated on 8/6/2025.In an interview on 8/13/2025 at 1:16 pm, Nurse Manager/Licensed Practical Nurse (NM/LPN) M reported care plans should be developed within 24-48 hours of admission. NM/LPN M reported that floor nurses are responsible for care plan development when a resident admits on a weekend.In an observation and interview on 8/13/2025 at 1:44 pm, Nurse Manager/Registered Nurse (NM/RN) N was observed creating a custom wound care plan for Resident #47 and reported she had been instructed by Director of Nursing (DON) B to create the wound care plans. NM/RN N reported the former wound nurse would create care plans related to wounds, and the position was vacated on 7/12/2025. NM/RN N reported she was not sure who was doing wound care plans after the position was vacated. NM/RN N reported that floor nurses could create care plans, with interventions that directly reflect the resident's assessment and/or Braden scale, but they were still working on the floor nurses doing it as they were not fluent in care plan language. NM/RN N reviewed Resident #47's skin care plan and stated, it's not good: I don't know what to say. NM/RN N reviewed Resident #47's medical record and noted that Resident #47 admitted to the facility on [DATE], when NM/RN N noted Resident #47's admission dates she exclaimed out loud OH MY GOSH! Did he go that long with no interventions? NM/RN N continued to review Resident #47's care plan and stated, What is documented in Resident #47's care plan is that there were no interventions in place until 8/5/25 after the wound on his coccyx was found, and then again on 8/11/25 when the wound on his left heel was found.In an interview on 8/13/2025 at 2:34 pm, Director of Nursing (DON) B reported Resident #47's had 3 wounds now and no wounds were not present on admission. DON B reviewed Resident #47's care plan and reported barrier cream was put in today, float heels was put in yesterday, draw sheet on 8/5/2025, turn and reposition on 8/5/2025, pressure relieving mattress put in on 8/12/2025. DON B stated Resident #47 had an air mattress on his bed since he admitted , but there was no care plan intervention in place. DON B stated if it wasn't documented it wasn't done. DON B reported that Resident #47 should have had pressure ulcer prevention interventions in place at admission, he was clearly at risk for pressure ulcers related to his Braden score, and her expectations were that interventions were put in place at admission when a resident was at risk for developing pressure (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	ulcers.Review of facility policy Careplan Standard Guideline with an effective date of 11/28/2017 revealed .All resident/client will be evaluated for individual risk factors.The interdisciplinary team will collect and record data within 24 hours for the admission baseline care plan.Interventions should be specific to reflect the specific goal. The intervention should be individualized to the resident.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide adequate care to prevent the development of pressure ulcers in 1 (Resident #47) of 5 residents reviewed for pressure ulcers resulting in Resident #47 developing pressure ulcers in the coccyx (the tailbone area of the body) and the left heel.Findings include:Resident #47Review of an admission Record revealed Resident #47 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: CVA (cerebral vascular accident/ stroke), hemiplegia of the left side (inability to move the left side of the body), peg-tube (percutaneous endoscopic gastrostomy tube- a tube inserted into the stomach to provide artificial nutrition) and aphasia (a disorder that affect show a person communicates).Review of a Minimum Data Set (MDS) assessment for Resident #47, with a reference date of 8/1/2025 revealed Section GG - Functional Abilities - Admission coding indicated Resident #47 was dependent on staff for activities of daily living (ADL) care and transfers. The MDS indicated he was at risk for pressure ulcers but did not have any unhealed pressure ulcers at the time of assessment. During an observation on 8/11/2025 at 8:47 am, Resident #47 was lying supine (on his back) in bed with a pillow under the left arm and was noted to have a PRAFO boot (pressure relieving ankle foot orthosis, a specialized device designed to support the foot and ankle, a plastic boot shaped shell with a soft liner that fastens to the leg with straps helping to maintain or increase the range of movements at the ankle) on the right foot. The left foot was noted to have a bandage wrapped around it and his left heel was resting directly on the mattress.Review of Kardex (a collection of instructions generated from a care plan for the certified nurse's assistants to reference that indicate the needs of the residents they are caring for) for Resident #47 revealed PRAFO boots on when in bed. bed mobility: Physical Assist.In an interview on 8/11/25 at 11:23 am, Family Member (FM) UU reported Resident #47 had been in the facility for almost 3 weeks and he now has multiple pressure wounds. FM UU reported Resident #47 did not have any wounds when he admitted to the facility. FM UU reported she felt that Resident #47 never should have gotten a pressure wound, and now she had to be present in the facility every day to make sure he gets the care she felt he should have.During an observation and interview on 8/11/2025 at 11:26 am, Resident #47 was observed in bed and was noted to be positioned supine with pillows under his right arm and his left elbow (the same position he was observed in approximately 3 hours earlier). No other pillows noted for positioning. Resident #47 was also noted to be wearing PRAFO boots on both his right and left foot. Noted on the dry erase board in the room was boots on 2 hours and off for 4 hours. Licensed Practical Nurse (LPN) T was present in the room administering a bolus (large dose of formula given all at once) to Resident #47. LPN T reported Resident #47 was dependent (required staff to perform all care and positioning) for all care and bed mobility, and that Resident #47 was to have his boots on when he was in bed.In an interview on 8/11/25 at 11:53 am, FM UU reported the wound physician explained to her that Resident #47's wound on his coccyx was due to him being wet with urine related to his incontinence. FM UU reported after the wound physician started caring for Resident #47, the facility staff started positioning him off his bottom. FM UU reported Resident #47 had been up in his wheelchair only one time since he was admitted to the facility. FM UU reported that Resident #47 had a wound on his left heel and the dressing should be changed every day and it was not being changed every day.Review of Nursing Evaluation- Section Skin for Resident #47 dated 7/26/2025 at 17:06 (5:06 pm) revealed does the resident have any skin integrity concerns? Answer -No.Review of Skin Observation for Resident #47 dated 7/26/25 at 17:48 (5:48 pm) revealed Does the resident have any NEW skin issues observed? Answer No. other observations.skin is intact. Review of Braden Score (a standardized, evident-based assessment tool used in healthcare to assess a patient's risk for developing pressure injuries) for Resident #47 dated 7/26/25 at 3:04 pm revealed 12 High Risk. Review of Care Plan for Resident #47 revealed Focus.The resident has an actual ADL (activities of daily living) self-care performance (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	deficit r/t (related to) his impaired strength, mobility, left sided weakness, communication and cognitive skills due to recent CVA. initiated on 7/26/2025.Goals.The Resident's ADLs needs will be anticipated and met by staff . initiated on 7/26/2025.Interventions.bed mobility physical assist.dressing physical assist.transfers: resident requires total/hoyer mechanical lift x 2 staff.bath shower max physical assist. all initiated on 7/26/2025.Focus. the resident has limited physical mobility r/t weakness and CVA with left sided weakness. initiated on 7/26/2025 resident will remain free of complications related to immobility, including contractures, thrombus formation (blood clots), skin-breakdown, fall related injuries. initiated on 7/26/2025.interventions. provide supportive care, assistance with mobility as needed. Document assistance as needed.initiated on 7/26/2025.Focus. the resident has bowel incontinence r/t functional, communication and cognitive limitations d/t (due to) recent CVA . initiated on 7/26/2025.Goal. The resident will remain free from skin breakdown due to incontinence and brief use.initiated on 7/26/2025.Interventions. provide pericare after each incontinence episode. initiated on 7/26/2025.Focus. The resident has potential for impairment to skin integrity r/t recent CVA with left sided weakness, decreased mobility, and strength, impaired safety awareness, cognition and communication skill deficits, bowel incontinent, gastrostomy tube, oxygen use, MASD (moisture associated skin damage).initiated on 7/26/2025. Goal. The resident will remain free of new skin impairment. initiated on 7/26/2025.Monitor skin when providing care, notify nurse of any changes in skin appearance. initiated on 7/26/2025.Review of Nutrition/Dietary Note for Resident #47 dated 7/31/2025 at 12:02, revealed .Resident with pressure area on heel, recommend 30 mL proheal critical care BID (twice a day) to further increase protein.Review of Skin Observation for Resident #47 dated 8/4/2025 at 15:12 (3:12 pm) revealed .Does the resident have a NEW skin issued observed? Answer Yes.Coccyx small open to gluteal cleft, measuring approx. 2 cm x 1 cm, coccyx also in gluteal cleft to the right of center, approx., 1.5 cm in diameter.Review of Health Status Note for Resident #47 dated 8/4/2025 at 17:18 pm (5:18 pm) revealed .small open area to inner gluteal cleft, see skin assessment for details. UM (unit manager) and NP (nurse practitioner) notified. orders for barrier cream.Review of Daily Skilled Nursing Note for Resident #47 dated 8/10/2025 at 15:09 (3:09 pm) revealed .Resident with pressure wound. Left heel and buttock.During an observation and interview on 8/12/2025 at 8:20 am, Resident #47 was lying supine in bed with a wedge noted on the left side of his body, and his left heel had a dressing present that was saturated and colored red, with his heel pressing directly on the mattress. FM UU present in the room reported that wound providers were present yesterday, and the coccyx wound was much worse and Resident #47 was not to wear the PRAFO boots any more. FM UU reported the dressings on Resident #47's wounds were not being changed like they should be. FM UU reported she was upset, frustrated, and concerned that Resident #47 was not getting out of bed, his dressings were not being changed, and he was not being moved around like he should be. FM UU reported the staff continues to tell her they were sorry Resident #47 has wounds now. FM UU stated Telling me sorry doesn't work for me, you need to do something.During an observation and interview on 8/12/2025 at 10:10 am, Resident #47 was noted to be sitting in his wheelchair outside on the patio with FM UU. FM UU reported that this was the second time Resident #47 was out of bed since he arrived at the facility.In an interview on 8/12/2025 at 2:10 pm, Certified Nurse Assistant (CNA) CC reported Resident #47 was dependent for cares, he needed to be rotated every two hours because he had a significant wound on his bottom, and he had to wear a boot on his one foot. CNA R reported Resident #47 should be turned from side to side every two hours when in bed, and to use pillows and wedges to keep him off his weak side. CNA CC reported Resident #47 should be changed every two hours. CNA CC and CNA R reported there was no place to document when a resident was repositioned. When queried regarding any wounds, CNA R stated he has gauze on the one foot, but I don't know if he has a wound under there.During an observation on 8/12/2025 at 2:13 pm, Resident #47 was sitting in his wheelchair in his room next to his bed. His left arm was hanging over the arm rest, extended straight towards the floor, and his entire upper body was leaning to the left side with his ribs pressed against the wheelchair arm rest. There was a pillow noted (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	between the wheelchair outer arm rest and the bed not in contact with the resident at all. A wedge (triangle shaped pillow) was present between the inside of the arm rest and Resident #47's left hip not under the resident. Resident #47's left foot was noted to be wrapped with gauze, soiled and saturated at the heel and resting in direct contact with the footrest of the wheelchair. Resident #47 was observed making facial grimacing and appeared to be uncomfortable. It was noted that Resident #47 had been sitting in his wheelchair (though not in this position) since the last observation at 10:10 am.On 8/13/2025 at 9:37 am, Resident #47 was observed positioned supine in bed, with his left heel wrapped with gauze, saturated and soiled at the heel and with the left heel laying in direct contact with the mattress of his bed.On 8/13/2025 at 9:45 am, Resident #47 was observed positioned supine in bed with both heels laying directly in contact with the mattress.During an observation and interview on 8/13/2025 at 9:50 am, the gauze dressing to Resident #47's left heel was noted to be saturated and soiled. The sheet beneath Resident #47's heel area was noted to be soiled in a circular pattern directly under where Resident #47's heel had been observed resting directly on the mattress. Wound Care Nurse/Registered Nurse (WCN/RN) S reported Resident #47's was followed by wound providers, and that they changed orders for his dressing changes yesterday. WCN/RN S reported Resident #47 he did not move himself in bed, needed total assistance for cares, and was no longer to wear the PRAFO boots. When queried, WCN/RN S reported that the provider changed the orders for his PRAFO boots on Monday due to his legs looking like bowling pins with edema. Resident #47's heel wound was noted to be malodorous when WCN/RN S removed the dressing. Resident #47's left heel wound was observed to be a slit shaped opening in the back of the heel with a darker circular shaped area that surrounded the slit in the back of the left heel. WCN/RN S reported Resident #47's left heel wound was not present on admission, that the wound was pressure related, and facility acquired. WCN/RN S reported that Resident #47's coccyx wound was caused by moisture from incontinence. During wound care and pericare WCN/RN S verbalized that she now noted a new pink area on the left side of Resident #47's scrotum that was not there yesterday. WCN/RN S was observed applying barrier cream to the left side of Resident #47's scrotum. WCN/RN S reported Resident #47 had care plan interventions in place such as floating heels on a pillow, turn every 2-3 hours, monitor wound weekly and take measurements and that she had put in those interventions when she started which was last week. WCN/RN S reported she was not sure if care plans were her responsibility or not, she was new and was still learning her role. In an interview on 8/13/2025 at 9:54 am, CNA EE reported that Resident #47 was a check and change every 2 hours. CNA EE reported that Resident #47 needed two people to assist to reposition him as he was very heavy.Review of Care Plan for Resident #47 revealed .focus.The resident has an actual ADL self-care performance deficit r/t his impaired strength, mobility , left sided weakness.interventions: PRAFO boots when in bed date initiated 8/11/2025.PT/OT (physical therapy/occupational therapy) evaluate and treat.initiated 8/11/2025.Focus.The resident has potential for impairment to skin integrity r/t CVA with left sided weakness, decreased mobility and strength, impaired safety.MASD.Interventions: apply barrier cream per facility protocol to help protect skin from excess moisture.initiated 8/11/2025.change bedding/clothing if moist.initiated 8/11/2025.Air mattress as ordered.initiated 8/11/2025.elevate heels while resting is lying in bed with heel protectors as he allows. initiated 8/11/2025.Turn and reposition resident every 2-3 hours, use wedge cushion.initiated 8/11/2025.Focus The resident has actual impairment to skin integrity MASD to coccyx and right buttock.initiated 8/5/2025.Goal. Resident's skin integrity will improve.initiated on 8/5/2025. Interventions. Educate resident/family caregiver of causative factors and measures to prevent skin injury. initiated 8/5/2025.ensure resident has bilateral (both feet) heel protecting boots on at all times as resident allows. initiated 8/5/2025. Keep skin clean and dry. Try to reduce as much moisture as possible 8/5/2025.turn and reposition eve3ry 2-3 hours and PRN (as needed). initiated 8/5/2025.Use a draw sheet or lifting device to move resident. initiated on 8/5/2025. Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudated (drainage) and any other (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	notable changes or observations initiated on 8/5/2025.Focus. Resident has condom catheter size large. the resident will show no s/sx (signs and symptoms) of urinary infection. initiated on 8/6/2025.In an interview on 8/13/2025 at 1:16 pm, Nurse Manager/Licensed Practical Nurse (NM/LPN) M reported care plans should be developed within 24-48 hours of admission and should include transfer status, bed mobility, dining needs, ADLs (activities of daily living) needs, and things like any assistive device needs. NM/LPN M reported that floor nurses are responsible for care plan development if a resident admits on a weekend.In an observation and interview on 8/13/2025 at 1:44 pm, Nurse Manager/Registered Nurse (NM/RN) N was observed creating a custom care plan for Resident #47 and reported she was responsible for creating care plan. NM/RN N reported she did not normally do wound care plans and had never created one before. NM/RN N reported she had been instructed by Director of Nursing (DON) B to separate out each of Resident #47's wounds and created a separate care plan for each of the 3 wounds that Resident #47 was documented to have now. NM/RN N reported care plans should be created 24-48 hours after admission, or ASAP (as soon as possible) and they included ADLs, transfer status, dining, showers, turn and reposition every 2 hours if needed. NM/RN N reviewed Resident #47's medical record and stated, What is documented in Resident #47's care plan is that there were no interventions in place until 8/5/25 after the wound on his coccyx was found, and then again on 8/11/25 when the wound on his left heel was found. NM/RN N continued to review Resident #47's record and stated, I just can't even, I know we did stuff, but nothing is documented here. NM/RN N reported Resident #47's pressure ulcers were not present on admission, and now the staff was using wedges for positioning since pillows did not work. Resident #47's boots (PRAFO boots) were just DC'd (discontinued), and Resident #47 just started to get out of bed in the last two days. NM/RN N reported that turning and repositioning were standards of care and reviewed Resident #47's medical record and reported there was no documentation by the CNAs when Resident #47 was being repositioned.Review of Care Management note for Resident #47 dated 7/30/2025 at 13:30 (1:30pm) revealed .Interdisciplinary Care Management Summary: The anticipated discharge date is 08//29/2025.The IDT (interdisciplinary team) agrees with plan of care.Review of Treatment Administration Record (TAR) for Resident #47 revealed .Condom cath.start date 8/6/2025.Weekly skin check every day shift every Wed (Wednesday) for skin integrity. start date 8/13/2025.Wound treatment - left heel, apply betadine to heel, cover with abd (abdominal) pad, secure and wrap with kerlix (rolled gauze) every day shift for wound management.start date 8/13/2025. wound treatment - left heel, apply betadine, cover with abd and kerlix every day shift for wound management. start date 8/7/2025.D/C date 8/12/2025. No documentation was noted indicating completion on 8/7/25, 8/8/2025 and 8/11/2025.Wound treatment: cleanse buttock with dakins and pat dry, apply santyl to wound bed, apply dakins soaked gauze dover santyl then cover with a bordered gauze once per day and as needed fi dressing becomes soiled every day shift for MASD. start date 8/13/2025. Wound Treatment: cleanse buttock with normal saline and pat dry, apply maxsorb to wound and cover with bordered gauze once per day and as needed if dressing comes soiled every day shift for MASD. start date 8/6/2025.D/C date 8/12/2025.with no documentation indicating completion on 8/11/2025 .Heel protector to Right heel for prevention every day and night shift. start date 8/13/2025.Heel protectors to prevent decubitus ulcers on the heels two times a day with a start date of 7/30/2025. D/C date 8/13/2025. no documentation was noted indicated completion on 8/9/2025 at 2000 (8pm). Reposition resident every 2-3 hours and PRN; use wedge cushion at resident's bedside to assist with reposition every 3 hours for MASD, pressure ulcer prevention with at start date of 8/5/2025.No noted documentation indicated completion was noted on 8/9/2025 at 2100 (9pm), 8/10/2025 at 0000 (midnight) and 0300 (3 am) and 8/13/2025 at 0300.In an interview on 8/13/2025 at 2:34 pm, Director of Nursing (DON) B reported Resident #47's had 3 wounds now and no wounds were not present on admission. DON B reviewed Resident #47's care plan and reported barrier cream was put in today, float heels was put in yesterday, draw sheet on 8/5/2025, turn and reposition on 8/5/2025, pressure relieving mattress put in on 8/12/2025. DON B stated (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #47 had an air mattress on his bed since he admitted , but there was no care plan intervention in place. DON B stated if it wasn't documented it wasn't done. DON B reported that Resident #47 should have had pressure ulcer prevention interventions in place at admission, he was clearly at risk for pressure ulcers related to his Braden score, and her expectations were that interventions were put in place at admission when a resident was at risk for developing pressure ulcers.Review of facility policy Skin Management Guidelines with an effective date of 11/28/2017 revealed .Purpose: to ensure residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measure and individualized interventions to prevent, reduce and treat skin breakdown.Prevention of Pressure Ulcers.All residents admitted to the facility will be evaluated for actual and potential skin integrity issues.the pressure injury notice will be completed and provided for the resident and/or resident representative providing notice of predicting factors and baseline care plan interventions to support prevention, treatment and healing.A. turning and repositioning observation (tissue tolerance) pressure is the primary cause of pressure ulcers. An effective turning and repositions schedule can help reduce the risk of developing a pressure ulcer.it is important to individualize each resident's turning and repositioning scheduled. Monitoring of skin integrity. The care plan for skin integrity is to be evaluated and revised based on response, outcomes, and needs of the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain best practices in accordance with professional standards of food service safety. The deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen.Findings include: On 8/11/25 at 7:40 AM, an interview with Manager in Training (MIT) HHH found that the kitchen date marks items made in house for 7 Days and would datemark sliced meats for 10 days. On 8/11/25 at 7:46 AM, observation of the walk-in cooler found a large chunk ham open with some pieces sliced from it. The ham was dated 8/6 to 9/15. On 8/11/25 at 8:02 AM, observation of the four door Traulsen cooler found the following items: a container of hardboiled eggs with no date, a container with sliced chunk ham dated 8/5 to 9/5, and a container of hot dogs dated 8/8 to 8/20. On 8/11/25 at 3:24 PM, observation of the Spiritual Garden kitchen found the following items: Sliced ham with no date, hot dogs in a plastic bag sitting in a container dated 7/15 to 8/15, a vanilla Med Pass 2.0 dated 8/6 to 8/10 with the product stating, consume within 4 days, and an open bag of lettuce with no discard date. On 8/12/25 at 8:00 AM, observation of the walk-in cooler found two bags of cilantro, one open, with best by dates of 7/20/2025. The product had portions that were brown in color and looked slimy to the touch. On 8/12/25 at 8:05 AM, observation of the four door Traulson cooler found hot dogs dated 8/8 to 8/20 and a container of ham dated 8/6 to 8/16. According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . On 8/11/25 at 8:11 AM, an interview with MIT HHH found that clean scoops are stored in a bin near the cook line. Observation of the mechanical scoop bin found two scoops with dried stuck on food debris on the inside of the scoop mechanism. Further observation found that an accumulation of crumb debris was evident in the bottom of the clean utensil bin. When asked about cleaning the clean utensil bins, MIT HHH stated that staff try to get to them twice a week. On 8/11/25 at 8:14 AM, observation of the clean pot and pans storage rack found two 1/8th pans and three 1/4 pans stacked and stored with water droplets and moisture accumulation between the pans. Further observation found a 1/4 pan with a golf ball size spot of oatmeal stuck on the inside of the pan. On 8/11/25 at 8:35 AM, observation of the main ice machine found some black accumulation on the inside plastic lip of the ice (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	machine. Particularly near the top hinge portion of the door of the unit. On 8/11/25 at 9:18 AM, a tour of the four bistros found heavy accumulation of dried stuck on food debris on the insides of all four bistro microwaves. Food District Manager (FDM) JJJ stated she would get staff to clean them. On 8/12/25 at 8:14 AM, observation of the clean pots and pans storage rack found six 1/4 pans stacked and stored with water accumulation between each pan. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. According to the 2022 FDA Food Code section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD. On 8/11/25 at 8:46 AM, A review of the facility document entitled Dish Machine Log, dated [DATE], located next to the dish machine, stated it required a Final Rinse: Minimum of 180F. Further observation of the log found temperatures were recorded for dishes done during Breakfast, Lunch, and Dinner each day. The log listed 30 final rinse temperatures from the 1st through the 10th of the month, with every final rinse temperature recorded below the required 180F. According to the 2022 FDA Food Code section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90C (194F), or less than:.(2) For all other machines, 82C (180F). On 8/12/25 at 7:55 AM, a revisit to the walk-in cooler found a large container of raw pork chops marinating on the storage shelf. Under the pork chops were a package of ready-to-eat hot dogs. On 8/12/25 at 8:11 AM, a revisit to the four door Traulson cooler found that shell eggs were stored on the second to the bottom shelf in the unit, and ready to eat peanut butter and jelly sandwiches were stored underneath the shell eggs. According to the 2022 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables,(b) Cooked READY-TO-EAT FOOD. On 8/11/25 at 8:40 AM, observation of the dry storage room found a brown aqueous substance lining the back left floor juncture of the room. When asked if she was knew what had happened, FDM JJJ stated it looked like something had spilled down the back wall and onto the floor. On 8/11/25 at 8:48 AM, Observation of the dish machine area found an accumulation of debris on the top of the dish machine as well as a dark brown splatter on the wall between the dish machine and the hand sink. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to provide care and services to promote dignity and respect for 8 of 8 residents who attended a confidential group meeting, resulting in feelings of frustration, decreased self-worth and embarrassment.Findings include: During an observation on 8/12/25 at 10:00am, an unknown Certified Nursing Assistant (CNA) on the heirloom unit, sat outside a resident's room and conducted a personal conversation using the speakerphone feature on her personal cellphone. The conversation could be heard from inside the occupied resident room.In a confidential group meeting on 8/12/25 at 1:00pm, 8 of 8 residents in attendance reported staff members used their personal cellphones, sometimes with earbuds, while providing care to them. One resident reported a staff member joined him in the bathroom, to assist with personal hygiene and completed the task while talking to someone via the use of earbuds. When queried, the resident reported he felt unimportant and embarrassed by the situation. A female resident reported she was left sitting naked on a shower chair while a CNA made a phone call on her cellphone outside the shower area. Another resident reported he was frustrated when he overheard a staff member arguing with her children on the cellphone while she waited for him in the bathroom.In an interview on 8/13/25 at 12:43pm, Nursing Home Administrator (NHA) A confirmed it was the expectation that staff would not use their personal cellphones during cares or in public areas while working.Review of a Dignity policy with a reference date of 12/21 revealed Each resident shall be cared for in a manner that promotes and enhances.dignity.Policy Interpretation.A. Residents shall be treated with dignity and respect at all times.H. Associates shall promote.resident privacy.during assistance with personal care.I. Demeaning practices .that compromise dignity are prohibited.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2586142Based on observation, interview, and record review the facility failed to: 1. provide an environment that was free from accident hazards for 2 residents (Resident #73 and Resident #40) of 5 residents reviewed for accidents. This deficient practice resulted in an elopement for Resident #73 and Resident #40 repeatedly walking unassisted thereby creating the potential for more than minimal harm. 2. To ensure wander alert equipment was working properly and effectively to ensure the safety of residents at risk for elopement. This deficient practice has the potential to impact 10 residents who currently require the use of personal wander alert devices and are at risk for elopement. Findings include: Resident #73 Review of an admission Record revealed Resident #73 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: parkinson’s disease (a disorder of the central nervous system that affects movement that may also cause hallucinations (sensory experiences that seem real but are created by the mind), metabolic encephalopathy (disorder that affects the brain’s function), weakness and anxiety (persistent state of worry). Review of a Minimum Data Set (MDS) assessment for Resident #73 with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #73 was cognitively intact. Section “E” of the MDS revealed Resident #73 wandered 1 to 3 days during the assessment. Section “GG” revealed Resident #73 required the use of a wheeled walker to safely ambulate. Review of a “Care Plan” for Resident #73 with a reference date of [DATE], revealed a focus/goal/interventions of: “Focus: (Resident #73) is an elopement risk/wanderer sundowner (phenomenon where those with cognitive impairments experience worsening of symptoms in the late afternoon or evening). Goal: The resident’s safety will be maintained…Interventions: exit and stairwell alarms…photo on wander list, staff aware of residents wander risk…wander ALERT personal safety device: Right ankle). Review of a “Wander/Elopement Risk Evaluation” with a reference date of [DATE] (Resident #73’s date of admission) revealed a score of “7”, low risk. Review of a “Wander/Elopement Risk Evaluation” with a reference date of [DATE] revealed a score of “14”, at risk. Review of “Physician’s Orders” for Resident #73 with a reference date of [DATE] revealed “Wander Device, Check Placement on right ankle every shift for elopement risk”. Review of a “Wander/Elopement Risk Evaluation” with a reference date of [DATE] revealed Resident #73 scored a “21”, high risk for elopement. In an interview on [DATE] at 2:51pm Certified Nursing Assistant (CNA) “C” reported Resident #73 frequently wandered around the building and could walk very fast. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 4:45pm, Director of Nursing (DON) “B” reported Resident #73 wandered frequently and got lost within the building. In an interview on [DATE] at 2:19pm, Licensed Practical Nurse (LPN) “Q” reported Resident #73 frequently wandered throughout the building, entered unauthorized areas such as the employee bathrooms and was exit seeking. In an interview on [DATE], at 2:26pm, Confidential Informant (CI) “DDD” reported they were caring for another resident in their room one afternoon, when they (CI “DDD”) looked outside and saw Resident #73 walking in the service driveway alone, without her walker. CI “DDD” reported this incident occurred “within the last few months”. CI “DDD” reported they ran outside and found Resident #73 alone, walking down the service drive of the facility, toward the front of the building, approximately 100’ from the emergency exit on her unit. CI “DDD” reported Resident #73 was not safe to leave the building alone because she got confused at times and lacked safety awareness. CI “DDD” reported LPN “MM” also responded to the situation and together they assisted Resident #73 back inside. CI “DDD” reported upon returning Resident #73 to the unit, she was approached by Nursing Home Administrator (NHA) “A” and DON “B” who instructed CI “DDD” not to document in the electronic medical record (EMR) regarding the incident. CI “DDD” reported following the incident, Resident #73’s room was moved because it was believed she exited the building through a door that was next to her room. In an interview on [DATE] at 11:07am, LPN “MM” reported Resident #73 eloped from the building and was found alone, walking briskly down the service drive, approximately 100’ from the nearest exit. LPN “M” reported she was unsure of the date of the incident, but an incident report had been written. When further queried about Resident #73’s elopement, LPN “MM” reported she was caring for a resident in room [ROOM NUMBER] when she heard a beeping alarm that sounded like a call light going off. LPN “MM” completed the cares and upon exiting room [ROOM NUMBER] noticed the beeping was much louder than a call light, at which time she recognized it as a door alarm. LPN “MM” reported she ran to the alarming door, went outside to the service driveway and saw CI “DDD” running toward Resident #73. LPN “MM” reported Resident #73 was approximately 100’ away from the door, walking briskly and that she had to run to catch up to the resident. Together, LPN “MM and CI “DDD” escorted Resident #73 back inside. LPN “MM” reported she told NHA “A” Resident #73 had eloped and that the door alarm had been sounding for a few minutes, but she didn’t recognize the sound of the alarm from behind a closed resident door. LPN “MM” reported she completed an incident report and assessed that Resident #73 was not injured. In an emailed response on [DATE] at 2:51pm, NHA “A” reported the facility had no incident reports related to Resident #73’s elopements. In an interview on [DATE] at 11:50am, Family Member (FM) “CCC” reported the facility called her twice since Resident #73’s admission to report the resident had eloped from the building. FM “CCC” reported the first elopement occurred shortly after the resident was admitted to the facility on [DATE] and again, “sometime in the last few months”. FM “CCC” reported she was the activated durable power of attorney (DPOA) for Resident #73 and did not want her to exit the building alone because she was not safe to do so. FM “CCC” stated “She (Resident #73) wanted to come to a facility rather go to her own (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	home after a hospitalization in 1/25 because she recognized she needed to have someone care for her”. FM “CCC” reported during the most recent elopement, Resident #73 was hallucinating and thought she saw her deceased daughter outside so Resident #73 exited the building to try to catch her. FM “CC” reported after Resident #73’s first elopement, the facility had implemented the use of a personal safety wander alert anklet to maintain her safety. FM “CC” reported after the second elopement, the facility moved Resident #73 to a room that was not as close to an exit door. In an interview on [DATE] at 3:11pm, Resident #73 reported sometimes she “gets a little out of sorts” and becomes confused. Resident #73 recalled becoming confused in the last few months and confirmed that she exited the building alone after she believed she saw deceased relatives outside. Resident #73 lifted her pant leg and gestured toward her personal safety device on her left ankle, then stated “it’s to keep me safe”. During an observation on [DATE] at 12:17pm, a delayed egress door was located next to the room that Resident #73 occupied from [DATE]-[DATE]. The egress alarm activated when the release bar was pushed, the door unlocked and opened after 15 seconds. There was no wander alert detector on the door. Beyond the door, a short sidewalk led to an 8” curb between the service driveway and employee parking area. The sidewalk ended on a curve between the service driveway and the employee parking lot. The service driveway was also accessible by walking across an area landscaped with river rocks and thick grass. The service driveway was paved with 2” deep cracks that stretched across the width of the drive. A retaining pond, enclosed by a 4’ fence, was on the opposite side of the drive. During an observation and interview on [DATE] at 8:47am, DON “B” toured the “Spiritual Garden”, a separate free-standing building, with this writer. DON “B” confirmed Resident #73 resided in this building now and her safety was maintained in part by use of a personal safety wander device. During the tour an exit door was noted in the service corridor. The service corridor was accessible through 2 unlocked, unalarmed double doors, the exit door (which led outdoors) was approximately 30’ beyond the double doors. The exit door had a wander guard detector and a delayed egress release bar. During an observation and interview on [DATE] at 8:55am, DON “B” activated the wander alert alarm at the exit door in the service corridor. The double doors leading to the service corridor were closed. The alarm was heard faintly by the surveyor while standing in the common area, in front of the nurse’s station. When queried, LPN “I” reported she could not hear the alarm as she stood next to the survey in front of the nurse’s station. LPN “I” was asked which residents in this building were at risk for elopement and how she would know. LPN “I” she would look in each resident’s electronic medical record to determine if they were at risk for elopement. LPN “I” listed residents she believed were at risk but did not include Resident #73. In an interview on [DATE] at 10:16am, DON “B” reported nurses were expected to use an electronic reader device each shift to ensure resident wander devices were working properly. DON “B” reported she thought the electronic reader devices were kept in the medication carts, but she was not sure. DON “B” reported she found a device reader at the front desk, but it was not charged. In an interview on [DATE] at 11:19am, Unit Manager/Registered Nurse (UM/RN) “N” (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Borgess Place	3057 Gull Road Kalamazoo, MI 49048

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported nurses should check each resident’s wander alert device every shift using the reader device. In an interview on [DATE] at 10:10am, LPN “I”, who was assigned to care for Resident #73 on this date, reported she checked the placement of the resident’s personal wander device daily but did not know how to check the functionality of the device. LPN “I” searched her medication cart and reported there was no reader device. LPN “I” reported she called DON “B” and was told the device was in the main building but was not currently useable because the batteries were not charged. In an interview on [DATE] at 10:23am RN “NN” reported she thought it was the expectation that nurses use the electronic reader device once a week to ensure resident wander devices were working properly. RN “NN” reported the facility only had 1 reader and it was kept at the front desk. In an interview on [DATE] at 10:25am, LPN “MM” reported she never checked resident wander devices to ensure they were working. LPN “MM” stated “someone else does that and they’ll let me know if it’s not working”. LPN “MM” checked each compartment of her medication cart and stated, “there’s no device in here for that”. In an observation and interview on [DATE] at 2:20pm LPN “Q” reported she was not responsible for checking resident wander devices to ensure they were working properly. LPN “Q” stated “someone from management checks them daily”. LPN “Q” reported she did not know where to find a wander device reader. In an interview on [DATE] at 10:17am, Central Supply Clerk (CSC) “Y” reported when she previously worked as the scheduler, it was her responsibility to check resident wander devices daily to ensure they were working properly. CSC “Y” reported there had been a lot of staff turnover for the scheduler position, and although she was covering scheduling at this time, the position was no longer had the responsibility of checking resident wander devices. In an interview on [DATE] at 3:41pm Maintenance Director (MD) “GG” report the facility placed wander detector devices on 2 of the 5 exit doors of the main building of the facility to reduce the likelihood of resident elopements. MD “GG” reported residents at risk for elopement wore a bracelet that triggered the wander detector when the resident was within 15’ of the door, which cause an alarm to sound. MD “GG” reported the wander detector devices at the doors were supposed to be checked weekly and the checks were documented in a “door log”. MD “GG” reported the remaining doors of the facility were all equipped with delayed egress locks that when activated, would only open after the release bar was pressed for 15 seconds. MD “GG” reported maintenance staff ensured the delayed egress locks were activated once a day, 5 days a week. MD “GG” reported there was no logbook for checking the delayed egress doors and there was no plan in place for checking the doors when maintenance staff was not in the building. MD “GG” reported nurses and other staff members had keys to activate and deactivate the delayed egress alarms. Review of a “Door Logbook” revealed 5 occurrences in which the wander alert alarms were not checked every 7 days during the date range of [DATE]-[DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 3:41pm a red light shone on the delayed release bar of the exit door near the kitchen of the main building. When queried, MD “GG” reported the delayed egress alarm was not activated but should have been. In an interview on [DATE] at 12:07pm, NHA “A” reported she thought she may have a “soft file” regarding an “incident of wandering” for Resident #73. NHA “A” then provided a manilla folder with a single document titled “Verification of Investigation”. Review of a “Verification of Investigation” report with a reference date of [DATE] revealed “(Resident #73) was noted with wandering behaviors and wandered through egress door to outside…staff immediately responded to alarm and went to resident…modified interventions to the plan of care… Resident’s room will be moved…further away from outside access…”. In an interview on [DATE] at 12:48pm, NHA “A” reported Resident #73 exited the building on [DATE]. NHA “A” reported the incident was not submitted to the state agency as required because she believed the incident was witnessed by staff. When further queried, NHA “A” reported she did not have any signed, documented staff interviews related to the incident and was not aware of any documentation of the event in the resident’s medical records. NHA “A” confirmed documentation of the event should be in the resident’s medical record so staff could be aware of potential hazards for the resident. NHA “A” reported she had no awareness of an elopement that occurred shortly after Resident #73’s admission because it had not been documented. Review of Resident #73’s progress notes for [DATE]-[DATE] revealed no documentation of elopement(s). Review of an “Accidents” facility policy with a reference date of [DATE] revealed “Purpose: To ensure the environment is free from accident hazards over which the facility has control and provide supervision…to each resident to prevent avoidable accidents through a systematic approach. “Avoidable Accident” means that an accident occurred because the facility failed to: …evaluate/analyze hazards and eliminate them…implement measures to reduce risks…implement interventions/including adequate supervision and assistive devices to…reduce risk of an accident…assistive device refers to any item…that is used by, or in care of a resident to promote…the resident’s safety….a systematic approach identifies equipment and devices that are defective…are disabled/removed…and enables leadership and direct care staff to work together to communicate the observation of hazards, record resident specific information,…monitor data related to care processes that potentially lead to accidents…” Review of a “Wandering and Elopement Guideline” with a reference date [DATE] revealed “This facility will provide the least restrictive and safe environment for wandering residents at risk for elopement. Process: Upon admission…and upon change of condition our residents will be evaluated for potential elopement risk…Residents identified at risk will have an elopement risk bracelet application placed…Bracelets will be checked for placement and function every shift…” Resident #40 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an admission Record revealed Resident #40 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: weakness, reduced mobility, other muscle spasms, and cutaneous abscess of right foot (a localized collection of pus within the skin and underlying tissues). Review of a Minimum Data Set (MDS) assessment for Resident #40, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #40 was cognitively intact (BIMS score 13-15 indicates no cognitive impairment); “Section GG-Functional Abilities- I. Walk 10 feet: Once standing the ability to walk at least 10 feet in a room, corridor, or similar space… Coded “04- defined as “Supervision or touching assistance- Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently.” On [DATE] at 8:03 am, Resident #40 was observed walking in the hallway towards her room. Resident #40 was walking unassisted with a two wheeled walker approximately 3 feet behind “Certified Nursing Assistant” (CNA) “L” as they returned to Resident #40’s room from the spa room. CNA “L” was walking in front of Resident #40 and did not have her in any direct visualization. Resident #40 was not wearing a gait belt. (a safety device used to assist individuals with mobility issues, worn by patients, and allows caregivers to safely move or support the patient while walking or transferring.) On [DATE] at 9:15 am, Resident #40 was observed walking alone with a two wheeled walker in the hallway outside of her room. No noted staff present in the hallway. On [DATE] at 10:29 am, Resident #40 was observed walking alone with a two wheeled walker in the hallway outside of her room. No noted staff present in the hallway. In an interview on [DATE] at 8:26 am, “Registered Nurse” (RN) “PPP” reported Resident #40 was “able to get up and walk around alone”. On [DATE] at 9:45 am, Resident #40 was observed walking out of her room into the hallway with her two wheeled walker alone. Resident #40 was overheard speaking to two transport individuals requesting the use of a wheelchair since going to the doctor was “too long of a walk for her to make without falling.” RN “PPP” was observed entering Resident #40’s room, retrieving a wheelchair, and placing the wheelchair in the hallway for Resident #40 to sit in. Resident #40 was overheard stating “the last thing I want to do is fall and break something.” RN “PPP” looked at this surveyor and stated, “she can be up by herself.” Review of “Kardex” (a easily referenced key patient information system that originates from the patient’s nursing care plan) for Resident #40 with a review date of [DATE] revealed “…Mobility…Uses walker, uses wheelchair (foot pedals as needed), I use a wheelchair in hallways, walker in room with assist, (Name Omitted) Resident #40 can walk with stand by assist with two wheel walker and gait belt in room…” In an interview on [DATE] at 11:56 am, “Director of Rehab” (DOR) “FFF” reported that she was new to the director position and stated, “we are not great at getting evaluation information like transfer status to the floor and the nursing staff.” (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:35 pm, Resident #40 was observed walking alone with a two wheeled walker in the hallway outside of her room. CNA “G and CNA “R” present in the hallway. No direct observation of Resident #40 by staff was noted. On [DATE] at 3:45 pm, Resident #40 was observed walking alone with a two wheeled walker in the hallway outside of her room. CNA “G” and CNA “R” were standing in the hallway observing Resident #40 from a distance while talking with this surveyor. In an interview on [DATE] at 3:45 pm, CNA “G” reported the management changes the resident’s care plan and doesn’t make sure we know it has been changed. CNA “G” reported the information for a resident’s transfer status was in the care plan and the Kardex but stated “who has time to check that every day?” In an interview on [DATE] at 3:45 pm, CNA “R” reported that Resident #40 walks in the hallway independently “all the time” and she does fine with it. In an interview on [DATE] at 3:45 pm, this surveyor walked next to Resident #40 in the hallway outside of her room and when queried, Resident #40 stated “I think I can be up walking in the hallway. The girls aren’t saying “(Name Omitted) get back to your room”. Resident #40 stated “I just look both ways and go for it. I’ll wait to hear if I’m not supposed to walk alone in the hallway.” In an interview on [DATE] at 8:59 am, DOR “FFF” reported Resident #40 was evaluated by therapy on [DATE] and her current status was “supervision” for assistance. DOR “FFF” reported that Resident #40 required the wearing of a gait belt and staff presence when walking in the hallway; DOR “FFF” reported staff did not have to touch her when she was walking, but they did need to observe/supervise her when she walked in the hallway. DOR “FFF” reported Resident #40 was not independent in walking in the hallway. Review of “Physical Therapy PT evaluation and Plan of Treatment” for Resident #40 dated [DATE] revealed “…new goal Resident will be able to function and ambulate (walk) independently on the hallway with her 2WW (two wheeled walker) safely > (greater than) 150 feet and back (target date [DATE]) …baseline… currently ambulating with 2WW at supervision…” In an interview on [DATE] at 1:16 pm, “Nurse Manager/Licensed Practical Nurse” (NM/LPN) “M” reported that therapy department did not have access to update care plan interventions, and any changes should be made by nursing staff and/or nurse managers. NM/LPN “M” reported she received an email if therapy made changes to a resident’s transfer status and the floor nurse received a communication form from the therapy department if changes were made. In an interview on [DATE] at1:30 pm, CNA “F” reported Resident #40 was independent now. When queried about how CNA “F” knew that Resident #40 was independent, CNA “F” stated “she shows me she is independent when she does things for herself.” In an interview on [DATE] at 1:35 pm, CNA “EE” reported Resident #40 staff needs to be in the room when Resident #40 was doing ADLs (activities of daily living), but she would walk the unit (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by herself. CNA “EE” reported Resident #40 has a “walking routine” that she completed with therapy during her sessions and she would practice it when she wasn’t working with therapy by walking around the unit by herself. In an interview on [DATE] at 2:27 pm, “Director of Nursing” (DON) “B” reported her expectations were that care plans were updated when needed and consistently done quarterly with the quarterly assessments. DON “B” reviewed Resident #40’s care plan and confirmed Resident #40 should have a gait belt on and staff standing by; Resident #40 should not be walking independently in the hallway.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2586142Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records in 5 of 18 residents (Resident #10, #99, #100, #73 & #47) reviewed for accuracy of medical records, resulting in inaccurate treatment records and the potential for providers to not have an accurate picture of resident status and condition.Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing.High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized . Accessed from: Kindle Locations 24106-24108). Elsevier Health Sciences. Kindle Edition. Resident #10: Review of an admission Record revealed Resident #10 was a female with pertinent diagnoses which included paralysis on her right dominant side, stroke, long term use of insulin, pain in right shoulder, tube feeding, NPO (nothing by mouth), and nerve pain. In an interview on [DATE] at 2:11 PM, Licensed Practical Nurse (LPN) D reported in the medication administration and treatment administration records (MAR TAR) if a resident refused, the nurse would document the refusal in there. For some refusals, it would bring up a note for the nurse to document or the nurse could create their own note for the progress notes. In an interview on [DATE] at 2:15 PM, LPN PP reported in the MAR/TAR, if a resident refused they would select refused and put in a progress note for the resident's refusal. Review of Treatment Administration Record (TAR) for [DATE], revealed, .Acetaminophen Tab 325 mg .Give 2 tablet via peg tube every 6 hours for pain . On [DATE]: missing notation of administration of medication and pain level assessed. Review of Treatment Administration Record (TAR) for [DATE], revealed, .one time a day for Pleasure .Resident to have ice cream once daily. Sitting up at a 90 degree angle, and can be fed by nurse, SLP (speech language pathologist) or trained activity staff only .Trained activity staff are: (First name), (First name), and (First name) .For pleasure feeding On [DATE]: missing notation of administration for administration of pleasure feeding for Resident #10. Review of Treatment Administration Record (TAR) for [DATE], revealed, .Enteral Feed Order at bedtime Change drain sponge around G tube q (every) HS (hour of sleep) . On [DATE]: missing notation of administration for Bedtime drain sponge change around G tube for Resident #10. Review of Treatment Administration Record (TAR) for [DATE], revealed, .Acetaminophen Tab 325 mg .Give 2 tablet via peg tube every 6 hours for pain . On [DATE]: missing notation of administration of medication and pain level assessed. Review of Treatment Administration Record (TAR) for [DATE], revealed, .Insulin Glargine-yfgn 100 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	UNIT/ML Solution pen-injector .Inject 30 unit subcutaneously two times a day related to TYPE 2 DIABETES MELLITUS WITH OTHER DIABETIC KIDNEY COMPLICATION (E11.29) . On [DATE]: missing notation of administration of medication at bedtime and results of blood sugar check. In an interview on [DATE] at 2:19 PM, Unit Manager (UM) “N” reviewed Resident #10's MAR/TAR and reported if an entry was not there, it was assumed it was not done as the staff could not be sure the resident had received the medication or treatment. UM N reported the Director of Nursing (DON) created a report in the electronic medical record to audit if a medication or treatment was missing. UM N reported that the nurse who was assigned to the resident during the missing documentation would be contacted to determine if this was just an omission or the medication/treatment was not completed. UM N reviewed Resident #10's MAR/TAR for June, July and August. UM N reported if the sponge was not changed on the G-tube this could cause infection. UM N reported if scheduled pain medication was missed the resident's pain could get out of control and the facility could have trouble getting it back under control. UM N reported that if the blood sugar and insulin were not completed it could have significant consequences for the resident. In an interview on [DATE] at 2:43 PM, Director of Nursing (DON) “B” reported every morning the clinical staff reviewed the progress notes from the day prior. DON “B” reported when she was a floor nurse she would put in a progress note and noted on the MAR/TAR the resident had refused the medication or treatment as she was unsure of the policy. Resident #99 (R99) / Resident #100 (R100) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R99 admitted to the facility on [DATE] with pertinent diagnoses including spinal fracture and alcohol abuse. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R99 was cognitively intact (13 to 15 cognitively intact). R99 had a previous admission at the facility from [DATE] to [DATE]. During an observation on [DATE] at 8:18 AM, Certified Nursing Assistant (CNA) “KK” was sitting outside R99’s bedroom door. CNA “KK” stated that R99 was on a 1:1 observation at all times for several days but she didn’t know why. During an interview on [DATE] at 8:38 AM, R99 stated that he was on 1:1 observation since he went into a resident’s room (R100) the other day. During an interview on [DATE] at 8:31 AM CNA “RR” said that she thought R99 was on 1:1 observation since he was inappropriate with a female resident. During an interview on [DATE] at 8:37 AM, Licensed Practical Nurse (LPN) “T” stated that R99 was on 1:1 observation but she didn’t know why. Review of R99’s chart revealed a behavior note documented by Licensed Practical Nurse (LPN) “LLL” from a previous admission dated [DATE] “Location/Cause: Resident room, passing AM medication Behavior: Resident grabbing at nurses breast and groin, started fondling self. Description of behavior: sexually inappropriate. Behavior/Intensity: Non Pharmacological Interventions: spoke with resident stated I am your nurse and this is not appropriate to grab me.” (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 12:28 PM, LPN “LLL” stated that the incident occurred when she was taking R99’s vitals. LPN ‘LLL” said she told her supervisor about the incident and documented the behavior in a progress note. LPN “LLL” said that R99 was sexually inappropriate and was often seen touching his private area in his bed. During an interview on [DATE] at 12:49 PM, Nurse Manager (NM) “N” stated that R99 was on 1:1 since [DATE] since he was found in R100’s room. NM “N” said R100 was next to his room and she was moved immediately afterwards. During a telephone interview on [DATE] at 11:57AM, LPN “OO” stated that she was working the day of the incident with R99 and R100. LPN “OO” said that FM “VV” told her what happened and that R99 was not observed touching R100. Then, she notified Director of Nursing (DON) “B” and DON “B” contacted NHA “A”. LPN “OO” said she didn’t complete an incident report or complete any charting related to incident since NHA “A” came in and she thought she would take care of it. During an interview on [DATE] at 8:24 AM, RN “NN” stated that when she walked into R99’s room several times he appeared to be masturbating. She also said he likes to brush up against staff but she hadn’t observed any behaviors with residents. RN “NN” stated that management knew about R99’s sexual behaviors since Wound Care Nurse (WCN) “S” told some staff to keep an eye on R99 since he was on the Michigan Sex Offender Registry List. During an interview on [DATE] at 9:02 AM, WCN “S” reported that she knew R99 was on the Michigan Sex Offender Registry List since he came from another facility where she worked at. WCN “S” stated that some staff were aware of R99 being on the list and his behaviors since she told some CNAs and the nurse when she had to do a skin assessment on R99 upon his admission. Review of both R99’s and R100’s charts revealed that there was no documentation of the incident on [DATE]. Review of R99’s chart revealed no behaviors documented since admission. Review of Social Services Evaluation completed on [DATE] by Social Service Assistant (SSA) “HH” revealed “…. Screening for Abuse/Neglect…8. History of or presence of behaviors, such as provoking, aggressive manner, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention seeking, and/or otherwise abrasive/inappropriate behavior: Yes…9. History of mistreating others (i.e. verbal/physical/sexual/ financial exploitation) and/or information presented by a reliable source that indicates there is a history of mistreating others: Yes” During an interview on [DATE] at 10:37 AM, Social Worker Director (SWD) “FF” and Social Worker Aide (SSA) “HH” stated that they were not aware of the incident between R99 and R100 on [DATE] since they weren’t part of the investigation, they only knew R99 had a 1:1 staff observation. Social Worker Director (SWD) “FF” and Social Worker Aide (SSA) “HH” also noted that the behavior log didn’t document any of the behaviors R99 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was exhibiting with staff. SSA “HH” acknowledged this. During an interview on [DATE] at 10:44 AM, NHA “A” stated that she did not have an incident report for the (R99) and (R100) incident on [DATE] or an incident report from the previous admission from [DATE] with LPN “LLL”. NHA “A” acknowledged that there was no documentation in R99’s or R100’s chart regarding the incident on [DATE]. Resident #73 Review of an admission Record revealed Resident #73 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: parkinson’s disease (a disorder of the central nervous system that affects movement and may also cause hallucinations (sensory experiences that seem real but are created by the mind), metabolic encephalopathy (disorder that affects the brain’s function), weakness and anxiety (persistent state of worry). Review of a Minimum Data Set (MDS) assessment for Resident #73 with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #73 was cognitively intact. Section “E” of the MDS revealed Resident #73 wandered 1 to 3 days during the assessment period. Section “GG” revealed Resident #73 required the use of a wheeled walker to safely ambulate. Review of a “Care Plan” for Resident #73 with a reference date of [DATE], revealed a focus/goal/interventions of: “Focus: (Resident #73) is an elopement risk/wanderer sundowner (phenomenon where those with cognitive impairments experience worsening of symptoms in the late afternoon or evening). Goal: The resident’s safety will be maintained…Interventions: exit and stairwell alarms…photo on wander list, staff aware of residents wander risk…wander ALERT personal safety device: Right ankle). In an interview on [DATE], at 2:26pm, Confidential Informant (CI) “DDD” reported they were caring for another resident in their room one afternoon, when they (CI “DDD”) looked outside and saw Resident #73 walking in the service driveway alone, without her walker. CI “DDD” reported this incident occurred “within the last few months”. CI “DDD” reported they ran outside and found Resident #73 alone, walking down the service drive of the facility, toward the front of the building, approximately 100’ from the emergency exit on her unit. CI “DDD” reported Resident #73 was not safe to leave the building alone because she got confused at times and lacked safety awareness. CI “DDD” reported LPN “MM” also responded to the situation and together they assisted Resident #73 back inside. CI “DDD” reported upon returning Resident #73 to the unit, she was approached by Nursing Home Administrator (NHA) “A” and DON “B” who instructed CI “DDD” not to document in the electronic medical record (EMR) regarding the incident. CI “DDD” reported following the incident, Resident #73’s room was moved because it was believed she exited the building through a door that was next to her room. In an interview on [DATE] at 11:07am, LPN “MM” reported Resident #73 eloped from the building and was found alone, walking briskly down the service drive, approximately 100’ from the nearest exit. LPN “M” reported she was unsure of the date of the incident, but an incident report had been written in the resident’s electronic medical record. LPN “MM” reported she told NHA “A” Resident #73 had eloped. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Borgess Place	3057 Gull Road Kalamazoo, MI 49048

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:50am, Family Member (FM) “CCC” reported the facility called her on two separate occasions to report Resident #73 had eloped from the building. FM “CCC” reported the first elopement occurred shortly after the resident was admitted to the facility on [DATE] and again, “sometime in the last few months”. In an interview on [DATE] at 3:11pm, Resident #73 reported sometimes she “gets a little out of sorts” and becomes confused. Resident #73 recalled becoming confused in the last few months and confirmed that she exited the building alone after she believed she saw deceased relatives outside. Resident #73 lifted her pant leg and gestured toward her personal safety device on her left ankle, then stated “it’s to keep me safe”. Review of Resident #73’s progress notes for [DATE]-[DATE] revealed no documentation of elopement(s). In an emailed response on [DATE] at 2:51pm, NHA “A” reported the facility had no incident reports related to Resident #73’s elopements. In an interview on [DATE] at 12:07pm, NHA “A” reported she thought she may have a “soft file” regarding an “incident of wandering” for Resident #73. NHA “A” then provided a manilla folder with a single document titled “Verification of Investigation”. Review of a “Verification of Investigation” report with a reference date of [DATE] revealed “(Resident #73) was noted with wandering behaviors and wandered through egress door to outside…staff immediately responded to alarm and went to resident…modified interventions to the plan of care… Resident’s room will be moved…further away from outside access…”. In an interview on [DATE] at 12:48pm, NHA “A” reported Resident #73 exited the building on [DATE]. NHA “A” reported the incident was not submitted to the state agency as required because she believed the incident was witnessed by staff. When further queried, NHA “A” reported she did not have any signed, documented staff interviews related to the incident and was not aware of any documentation of the event in the resident’s medical records. NHA “A” reported she had no awareness of an elopement that occurred shortly after Resident #73’s admission because it also was not documented in the medical record. NHA “A” confirmed that each resident’s medical record should contain all the information necessary for staff to maintain the resident’s safety, including past elopements. Resident #47 Review of an admission Record revealed Resident #47 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: CVA (cerebral vascular accident/ stroke), hemiplegia of the left side (inability to move the left side of the body), peg-tube (percutaneous endoscopic gastrostomy tube- a tube inserted into the stomach to provide artificial nutrition) and aphasia (a disorder that affect show a person communicates). Review of “Treatment Administration Record” (TAR) for Resident #47 for the month of [DATE] revealed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	“…Wound Treatment- Left heel: apply betadine, cover with abd (abdominal) pad and kerlix (a long continuous wrap of gauze) every day shift for wound management with a start date of [DATE] and a D/C (discontinuation) date of [DATE]… there was no noted, documentation for completion on [DATE], [DATE] nor [DATE]… Wound treatment: cleanse buttocks with normal saline and pat dry, apply maxsorb (an alginate material that absorbs drainage and turns into a gel that creates a moist wound environment for healing) to wound and cover with boarder gauze once per day and as needed if dressing becomes soiled every day shift for MASD (moisture associated skin damage) with a start date of [DATE] and a D/C date of [DATE], there was no noted documentation for completion on [DATE], the date was blank . Ammonium Lactate External Lotion 5% .Apply to arms and legs topically every morning and at bedtime for dry skin with a start dates of [DATE]… there was no noted documentation for completion on [DATE] at bedtime… Heel protectors to prevent decubitus ulcers on the heels two times a day with a start date of [DATE] and a D/C date of [DATE] with no noted documentation of completion on [DATE] at 2000 (8 pm)… Reposition resident every 2-3 hours and PRN (as needed); use wedge cushion at resident’s bedside to assist with repositioning every 3 hours for MASD, pressure ulcer prevention with a start date of [DATE] with no noted documentation of completion on [DATE] 21:00 (9:00 pm), [DATE] at 0000 (12:00 am) and 0300 (3:00 am)…” During an observation on [DATE] at 11:49 am, “Licensed Practical Nurse” (LPN) “T” was observed performing oral suctioning on Resident #47. Review of the “TAR” for Resident #47 revealed “…May suction as needed as needed for secretions with a start date of [DATE] and the only noted documented date of suctioning was [DATE]…” During an interview on [DATE] “Nurse Manager/Registered Nurse” (NM/RN) “N” reported that dressing changes and treatments should be documented in the record. NM/RN “N” reported that documentation was required when performing oral suctioning for Resident #47. NM/RN “N” stated “If it wasn’t documented, it wasn’t done”.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the explanation of their binding arbitration agreement was explained in a clear and concise manner to residents to ensure understanding at admission for 3 (Resident #71, Resident #37, and Resident #27) and 8 more residents during a confidential group meeting, resulting in residents expressing confusion and concerns regarding entering into and agreeing to a binding arbitration agreement.Findings include:In an interview on 8/11/2025 at 9:15 am, Nursing Home Administrator (NHA) A reported the facility did not maintain a list of residents who signed a binding arbitration agreement. NHA A informed this surveyor arbitration agreements were in the resident's records and cold be viewed there. This surveyor requested a list of current residents who had signed a binding arbitration agreement.Review of a word document provided by NHA A including a list of residents who signed a binding arbitration agreement, included Resident #27, Resident #37, and Resident #71. Resident #71Review of an admission Record revealed Resident #71 was a female who originally admitted to the facility on [DATE] and had pertinent diagnosis which included: schizophrenia.Review of Resident #71's admission agreement revealed Resident #71 signed accepting agreement to arbitrate health care negligence claims on 3/19/2025.In an interview on 8/12/2025 at 10:20 am, Resident #71 reported she had no recollection of signing a binding arbitration agreement and had no idea what it was. After explaining to Resident #71 the basics of a binding arbitration agreement Resident #71 reported she would not agree to it. Resident #71 stated I would never sign anything like that. Resident #37Review of an admission Record revealed Resident #37 was a male who originally admitted to the facility on [DATE] and had pertinent diagnosis which included: sepsis (infection of the blood).Review of Resident #37's admission agreement revealed Resident #37 signed declining agreement to arbitrate health care negligence claims on 7/11/2025.In an interview on 8/12/2025 at 10:32 am, Resident #37 stated . I was pretty drugged when I got here, I signed whatever they put in front of me. Resident #37 reported he had no idea what a binding arbitration agreement was, had no recollection of it being explained to him, and he would need to consult with a lawyer to determine if he should sign an arbitration agreement or not. Resident #27Review of an admission Record revealed Resident #27 was a female who originally admitted to the facility on [DATE] and had pertinent diagnosis which included: hemiplegia and hemiparesis following cerebral infarction affecting the right dominate side (inability to move the right side of the body, following a stroke).Review of Resident #27's admission agreement revealed Resident #27 signed accepting agreement to arbitrate health care negligence claims on 11/12/2024.In an interview on 8/12/25 at 11:39 am, Resident #27 reported she had no idea what a binding arbitration agreement was, she did not sign it, and if she did sign it, she had no idea what she was signing at the time.In an interview on 8/12/2025 at 11:21 am, Director of Admissions (DOA) X reported she did not know if the arbitration agreement could be rescinded. DOA X reported if a resident wanted to rescind an arbitration agreement, she would have to complete the admission agreement in its entirety again. When queried, how she explained to admitting residents what a binding arbitration agreement was, DOA X stated I explain it to the residents as do you want a mediator if you sue us or not.In an interview on 8/12/2025 at 11:49 am, DOA X reported she was responsible for completing the arbitration agreement with residents at admission. DOA X reported some residents read it and others do not. The ones that don't read it ask me to explain it. DOA X reported she explains it as Yes for a mediator, no for no mediator. DOA X reported she also signed binding arbitration agreements for resident to agree to enter into a binding arbitration agreement. DOA X reported when she signed the agreement it indicated she had explained the arbitration agreement to the resident.During a confidential resident meeting with 8 residents in attendance, it was communicated to the surveyors that none of the residents in attendance knew what a binding arbitration agreement was, how it (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	worked, nor if they had agreed to it. Review of a word document provided by NHA A including a list of residents who signed a binding arbitration agreement, included 5 or 8 residents had signed binding arbitration agreements at admission. In an interview on 8/13/2025 at 2:17 pm, NHA A reported binding arbitration agreements were completed at admission, and if the resident entered into an agreement, they have the right to change their mind and there was no time limit for the change. When queried, NHA A stated do they (the resident) want a mediator, or do they want a lawyer, that's how I understand it, but I'm not the person who does the agreements or the education.

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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. Based on observation and interviews, the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living. Findings include:During an observation on 08/11/2025 at 8:21 AM, This writer observed outside of room T64 was a sit to stand, the base of it had white powder, dust debris on the it and the footrest had it on it as well. This writer observed the pad where the knees go between the pad and the metal frame had dirt, debris, and white powder. During an observation on 08/11/2025 at 9:19 AM, This writer observed outside of room T67 there was a sit to stand there which had a plastic bag with wipes in it, The foot base and the metal bar where the pad and straps meet at there was dirt and debris there as well. During an observation on 08/12/2025 at 8:47 AM, This writer observed outside of room T64 was a sit to stand, the base of it had white powder, dust debris on the it and the footrest had it on it as well. This writer observed the pad where the knees go between the pad and the metal frame had dirt, debris, and white powder. During an observation on 08/13/2025 at 9:16 AM, This writer observed outside of room T71 a sit to stand which was observed to have dirt, debris, and several crumbs on the footrest area. There was also white powder, dirt, debris where the knee pad and straps attach to the metal frame. There was heavy white powder covering the wide grey base where the stem was located. The stem from the handles to the hydraulics meeting the base had dirt and debris. During an observation on 08/13/2025 at 9:42 AM, This writer observed a sit to stand outside of room T64, it was observed to have white powder, dirt, and food crumbs on the foot rest area, The straps where the knee guard was at had a white powdery substance on them as well as dirt and debris where they connected to the knee pad. The stem from the handles to the hydraulics meeting the base had dirt, debris and what appeared to be brown/tan dried liquid. In an interview on 08/11/25 at 8:48 AM Certified Nursing Assistant (CNA) NNN reported the CNAs were required to clean the resident shared equipment between each resident for infection control. In an interview on 08/13/25 at 3:04 PM, Nursing Home Administrator (NHA) A reported the staff should ensure the shared equipment was cleaned of dirt and debris after each use. Review of policy, Full Body Mechanical Lift Equipment and Guideline effective date 3.22.18, revealed, . Obtain the mechanical lift. Ensure the lift is powered and free of debris and dirt. Lifts should be cleaned prior to storing in-between resident use. Infection Control: Lifts should be cleaned in-between resident use and when visibility contaminated. On 8/11/25 at 1:43 PM, Observation of the CNA supply closet, on the Heirloom Unit, was found with numerous clean and sanitary items on the floor. These items included: mouth swabs, gloves, toothpaste, briefs, and gauze. Further observation found that slings stored on the bottom rack of the storage shelf were also laying off the rack and onto the ground. On 8/11/25 at 1:55 PM, Observation of the Oxygen room, on the Flower Garden Unit, found three packs of oxygen tubing laying on the ground. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/11/25 at 2:39 PM, Observation of the Spa room, on the Enchanted Unit, found clean and sanitary linens stored open and exposed on the counter of the sink. Further observation found dried bowel movement on the wheel of the shower chair.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure proper documentation and accurate advanced directive information was in place for 2 residents (Resident #102, Resident #98) of 3 residents reviewed for advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility with accurate documentation to support it. Findings include: Resident #102 (R102) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R102 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS) reflected a score of 12 out of 15 which indicated R102 had moderate cognitive impairment (8 to 12 cognitively impaired). Review of R102's Facesheet revealed Code Status: Advance Directives: DNR (Do not resuscitate). Review of R102's Orders revealed Advance Directive: DNR. Review of R102's chart revealed no documentation or signed paperwork to indicate that R102 wanted to be a DNR. During an interview on [DATE] at 1:45 PM, R102 was very tired and didn't want to talk to this surveyor since she just admitted to the facility the day before. During an interview on [DATE] at 8:33 AM, Nurse Manager (NM) N stated that since R102's DNR paperwork wasn't in her chart, it should be in a book at the nurse's station. NM N looked in the book and couldn't find R102's paperwork. During an interview on [DATE] at 4:21 PM, Social Service Aide (SSA) HH stated that the physician just signed R102's DNR paperwork on [DATE] and it was uploaded into her chart that day. SSA HH reported that all residents should be a full code when they are admitted until the social worker (SW) gets the physician signature for a DNR status because the SW needs to make sure the resident is competent to sign a DNR. SSA HH stated that everyone should be a full code until a DNR status was verified and signed by a physician. During an interview on [DATE] at 10:58 AM, Nursing Home Administrator (NHA) A stated she was aware of the code status on R102's facesheet and the missing documentation of R102's DNR status in the chart. Review of the Advance Directives and Care Planning Guidelines with an effective date of [DATE] revealed . Procedure D. All advance directive document copies will be obtained and located within the medical record. E. The advance directives are present within the medical record for the facility staff and physician. Resident #98 Review of an admission Record revealed Resident #98 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: displaced intertrochanteric fracture of right femur (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(type of hip fracture where the bone fragments have shifted out of their normal alignment). Review of a Minimum Data Set (MDS) assessment for Resident #98 with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #98 was cognitively intact. Review of current Physician Orders for Resident #98 with a reference date of [DATE] revealed Advanced Directives: Full Code, status active, with no end date. Review of a Michigan Systems Protocols DO-NOT RESUSITATE ORDER form for Resident #98 revealed I have discussed my health status with my physician. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order is in effect until it is revoked by me. Being of sound mind, I voluntarily execute this order, and I understand it's full import. Signed by Resident #98, Physician (MD) MMM, and 2 witnesses on [DATE]. In an interview on [DATE], at 7:58am, Resident #98 reported she did not feel the coordination of her care was going smoothly and staff didn't seem to always have information about her preferences, abilities, and needs. In an interview on [DATE] at 10:09am Social Worker (SW) HH reported a resident who completed a Michigan DNR (Do not Resuscitate) form that was signed by the physician should be listed as a DNR immediately in their medical record. In an interview on [DATE] at 12:43pm, Nursing Home Administrator (NHA) A reported it was the expectation that a resident's wishes regarding cardiopulmonary resuscitation be clarified and documented in their medical chart at the time of their admission. NHA A reported it was unacceptable for a resident's wishes to not be identified and accurately documented promptly because anything could happen within a few days and if their heart stopped, their wishes might not be followed unless they were correctly documented. Review of the banner (highlighted area with important resident information that is visible upon opening a resident's medical record) in Resident #98's electronic medical record (EMR) on [DATE] at 2:31pm revealed Advanced Directives: Full Code. The resident's EMR continued to inaccurately reflect the resident's wishes related to cardiopulmonary resuscitation (CPR).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. This citation pertains to Intake: 2569824Based on interviews and record review, the facility failed to protect the resident's right to be free from sexual abuse by staff for 1 (Resident #81) of 3 residents reviewed for abuse, resulting Resident #81 experiencing mental anguish, intimidation, and fear. Findings include: Resident #81: Review of an admission Record revealed Resident #81 was a female with pertinent diagnoses which included depression, and malaise (general feeling of discomfort). Review of a Brief Interview for Mental Status (BIMS) conducted on 5/1/2025, revealed, .BIMS score of 13 out of 15 which indicated Resident #81 was cognitively intact. Review of Care Plan for Resident #81 revised on 2/13/25, revealed the focus, .(Resident #81) has actual impairment to skin integrity to bilateral breasts and abd (abdominal) fold r/t (related to) yeast . with the intervention .antifungal treatment in place .Apply barrier cream per facility protocol to help protect skin from excess moisture .Monitor skin when providing cares, notify nurse of any changes in skin appearance . Review of Facility Reported Incident (FRI) received 7/12/2025, revealed, .Incident Summary: Resident reported that a couple weeks ago the treatment nurse touched her in her vaginal area. Residents were receiving treatment for fungal infection in groin and abdominal fold. The resident asked if she felt like the touching was sexual and she replied no, but she didn't like to be touched in that area. Resident stated she feels safe in facility.Police notified, Employee suspended.(Wound Nurse KKK) refused to provide a statement, he asked if he could record the conversation.is. (Resident #81) was recently being treated for a superficial mycosis fungal infection to her bilateral breast, abdominal folds and groin area twice a day, 7 days a week.Initial Complaint: On 7/12/2025 at approximately 10:30AM, Nurse Aide (CNA J) was giving (Resident #81) a shower in the spa room and mentioned ow much improvement her skin was showing. The areas to her breast, abdomen and groin had completely healed. (Resident #81) then stated to the Nurse Aide (CNA J) Yes, the wound care nurse comes to look at my skin, but I don't like the way he makes me feel. He makes me feel uncomfortable. He looks at my breast and he also put his finger in my vagina. I felt his fingers moving around. Nurse Aide (CNA J) immediately reported the allegation to the Nurse Manager (Licensed Practical Nurse (LPN) SS). The Nurse Aide (CNA J) and the Nurse Manager (LPN SS) instantly reported the allegation to Administrator. (Wound Nurse KKK), the Wound Care Director, was identified as the providing nurse. (Wound Nurse KKK), (who was not in the facility at the time the allegation was professed) was called by the Director of Nursing (DON) and suspended pending investigation. (Wound Nurse KKK) seemed surprised and confused hearing the news of the allegation.On 7/12/2025 the (Local) Police Department was called and the incident was reported. The Police came to the facility to interview (Resident #81). There was no further directives given by the Officers.On 7/14/2025 the (Wound Nurse KKK) came to the facility to speak with the Administrator and the Director of Nursing. At that time, the allegation was clearly explained to him. He then declined to respond to the allegation or to provide a statement. He left the facility and made no attempt to reach out again.On 7/14/2025 (Resident #81) was diagnosed with a Urinary Trach Infection (UTI).On 7/15/2025 the (Wound Nurse KKK) was terminated via telephone.Like residents were interviewed by Administration. There were no additional findings reported.Investigation Revealed: Upon hire, (Wound Nurse KKK)'s background check was clear. He completed education on Abuse and Neglect training prior to hire and again per the Company's guidelines.Action Taken: (Wound Nurse KKK) was immediately suspended pending investigation.The Licensed Nurse completed a full head-to-toe assessment on (Resident #81) which revealed no injuries. Her skin was clean, dry and intact and all areas with mycosis were healed.The (Local) Police Department was informed and interviewed (Resident #81) at the facility.Review of Statement submitted by CNA J dated 7/12/25, revealed, .When I was showering (Resident #81), I noticed her wounds under her breast looked so much better than when I noticed it a while back, I told her they look great. She stated, yes, the Wound Nurse KKK comes to look at them, but I don't like when he (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	does, he makes me feel uncomfortable. I asked her why do you say that, she stated When he was looking at my breast and also put his finger in my vagina, I then asked if he was assessing her for something and she stated No I felt him moving his fingers around, I then asked if this was only one time, and when was the most recent, she stated It happened 2 times in the past month When he came last week he only looked at my breast. (Resident #81) also stated she didn't know who to tell and that she didn't want to get anyone in trouble . Review of Statement submitted by Resident #81, dated 7/12/25, revealed, .When the Wound Nurse KKK was assessing under my breast and groin he put his finger in my vagina on 2 occasions. I offered to lay down in bed and he insisted that I was fine, and he could do the assessment while I was in my chair. It happened sometime last month. I feel it was wrong. I do feel safe here in the facility, I do not want my family to be notified. I also do not want to go to the hospital. In an interview on 08/12/2025 at 11:39 AM, Certified Nursing Assistant (CNA) J reported Resident #81 a few months ago had yeast infection under her breasts and CNA J reported she was happy it was finally healing. CNA J reported Resident #81 indicated she was happy the area was healing so the wound nurse wouldn't have to come and see her for them anymore. CNA J reported Resident #81 reported she doesn't like him, and he scared her. CNA J reported what Resident #81 told her Wound Nurse KKK had sexually assaulted as he had inserted his fingers into her vagina on two accounts in her room. CNA J informed Resident #81 she had to report what she just told her and after she finished Resident #81's shower she informed the nurse, and they contacted the nursing home administrator. CNA J reported there was nothing listed in her care plan which indicated she had wounds/skin breakdown in her vagina that would require an examination like that. CNA J reported the areas she had for the fungal infections were in the skin folds up by her hip area and not in her groin. CNA J reported she was interviewed by the police on two occasions to gather additional information. In an interview on 08/12/2025 at 12:24 PM, LPN SS reported CNA J told her Resident #81 informed her the Wound Nurse KKK had did somethings that were not appropriate and she stated he took pictures as well. LPN SS reported she immediately contacted the NHA (Nursing Home Administrator) and the DON. LPN SS reported she had assessed Resident #81. LPN SS reported Resident #81 had some yeast in her abdominal fold but nothing further down where there needed to be pictures taken of her in that area. LPN SS reported she had yeast in her abdominal area just above the pubis bone, MSAD (moisture associated skin damage) with her bottom but nothing in her vaginal area. Review of Wound Assessment Details Report dated 7/3/25, revealed Resident #81 had a fungal rash under her abdominal fold and her groin area where the panniculus (layer of fat tissue that accumulates in the lower abdomen, area above the pubic bone, which hangs down) and the upper part of her thigh meet up by the resident's hip. In an interview on 08/12/2025 at 3:31 PM, Resident #81 reported the Wound Nurse KKK had come in and informed her she needed to pull her slacks down, Resident #81 asked him for what reason? Resident #81 indicated he told her he needed to check her down there. Resident #81 reported she was seated in her recliner and had asked if he would like for her to lie down, and he said he could examine her there in the recliner. Resident #81 reported he had he went down the front of her abdomen, down into her vaginal area, and stuck his fingers up in her vagina, moved them around in there, back and forth, and he had stuck his fingers way up in there. Resident #81 reported she had experienced pain from it, and she informed this writer she had had a little bleeding after that occurred. Resident #81 stated, .I guess I was not smart enough to say to him, Keep your hands out of there .Naive I guess. (while she was shaking her head and her affect appeared distressed). Resident #81 reported if he would do that to me, she wanted to protect those who couldn't speak up. Resident #81 reported she didn't want to report it for a long time, and she had a hard time sleeping because of the incident. Resident #81 reported she felt safe in the facility, but she does worry if he would come back to the facility. Resident #81 reported she spoke to the police and had some counseling from social work since. Review of Social Services Evaluation dated 7/15/25, revealed, .Moderately Impaired: Score 12.0 .Reason for Evaluation: Incident reported .PHQ-2 to 9 (screen for depression and assess its severity): Mood: Feeling down, depressed, or hopeless .Yes .Frequency: 2-6 days (several days) (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Screening for Abuse/Neglect: History of abuse and/or neglect (including physical, sexual, verbal, emotional, financial) .Yes .Present mental health diagnosis: .Yes .Diagnosis of depression and/or history of depressive illness and/or present signs/symptoms of depression/mood distress. Low self-esteem, isolation and withdrawn behavior. Complaints of chronic pain, illness, fatigue, and/or persistent anger, fear, and/or anxiety .Yes .Risk Measure for likelihood of previous/recent mistreatment and psychosocial/psychological symptoms related to history of abuse and/or neglect .Moderate symptomology .Trauma Informed Care: Elder Abuse .Details: A few weeks ago during a skin check the nurse stuck his hands in my vagina after checking my breast and groin .How do you react when you are reminded of event(s)? .Dismissive .Trauma CP: Focus: (Resident #81) has potential Post Trauma ineffective coping r/t (related to): treatment of her abdominal and groin area .Encourage to talk about trauma at their own pace. Provide non-threatening environment, validate feelings, and include significant other/s if resident desires .Obtain accurate history from resident or significant others about trauma and resident's response .Evaluation completed following report on 7/12. The residents expressed feeling down for just a few days over the past two weeks. No changes in cognition. New trauma has been documented . In an interview on 08/12/2025 at 3:49 PM, Social Work Director (SWD) FF reported she was called in on a weekend to talk with Resident #81 in regard to the incident she reported. SWD FF reported Resident #81 had informed her Wound Nurse KKK had put his fingers in her vagina and she appeared not wanting to discuss it further. SWD FF reported Resident #81 was scheduled to see the mental health provider. Review of Psychiatric Evaluation & Consultation completed on 7/16/25, revealed, .She disclosed a sexual assault incident by a wound care nurse, involving vaginal penetration after application of medicated powder to her breast area. The event was reported and addressed by the facility; the involved staff member has been removed from care duties. (Resident #81) states the event remains distressing when she thinks about it but feels safe in the facility and appreciates their response. She denies suicidal ideation, homicidal ideation, hallucinations, or delusions .Mood: Sometimes sad and anxious .Affect: Congruent, tearful at times when discussing trauma.Diagnosis: Post-Traumatic Stress Disorder, Acute: Moderate: Undiagnosed new problem.Primary Insomnia: Moderate: Undiagnosed new problem.Current Assessment/Plan: (Resident #81) presents with chronic anxiety and depression, complicated by recent sexual trauma. She remains emotionally distressed when recalling the incident but expresses a sense of safety in the facility.Provide ongoing trauma-informed supportive psychotherapy.Nonpharmacologic interventions: Teach and reinforce deep breathing and grounding techniques.Encourage engagement in positive social interactions.Provide emotional validation and reassurance.Maintain trauma-sensitive care environment. Review of Employee Discipline Form for Wound Nurse KKK dated 7/15/25, revealed, .7/14/25: Employee came into facility to discuss the reported allegations of abuse and suspension. Employee declined answering questions or providing statement.7/15/25: NHA A and DON called employee to see if he would like to provide statement or answer questions in regard to the investigation and he declined. He stated if there was any information we had to share he would listen but was choosing not to answer questions.Recommendation for Termination was checked: Failure to participate in an open investigation, answer questions, or provide a statement. Review of Social Service Note (SPN) dated 7/15/2025 at 12:48 PM, revealed, .Evaluation completed following report on 7/12. Resident expressed feeling down just a few days over the past two weeks. No changes in cognition. New trauma has been documented. In an interview on 08/13/2025 at 9:20 AM, CNA U reported Resident #81 was normally social, and not one to make allegations against others. In an interview on 08/13/2025 9:25 AM CNA R reported Resident #81 was normally social, she would go and visit with other residents and would go and sing with another resident on the hallway. CNA R reported she was pretty independent but lately she had not been feeling well and required assistance. In an interview on 08/13/25 at 2:56 PM, DON B reported when queried Resident #81 had refused to go to the emergency room for evaluation. DON B reported she had interviewed Resident #81 following being notified of the resident's report to the CNA. DON B reported she had asked her to give me the details (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the incident and what she had told the CNA she reported it to. DON B reported Resident #81 reported a couple weeks prior to last week, Wound Nurse KKK had been in her room performing an assessment on her and she reported she had felt his fingers were inside of her vagina which he moved around in there. DON B reported she explained to Resident #81 the facility would contact the police and the steps the facility could do; she was offered to go to the hospital but Resident #81 felt it was not necessary. When queried, DON B reported Resident #81 did experience vaginal dryness and expressed she had vaginal discomfort as well as pain above the pubic bone. DON B reported Wound Nurse FFF was not on shift when the incident was reported. DON B reported she contacted him via the phone and informed him of his immediate suspension. DON B reported Wound Nurse FFF had come to the facility for a few minutes, NHA A asked him to give us a scenario of what happened, he refused, and NHA A explained the process to him and why the facility needed him to give us his side of the events. DON B reported he stated he didn't want to say anything at this time, and he was informed to reach out if he changed his mind. In an interview on 08/13/25 at 3:04 PM, NHA A reported she got a phone call from the LPN SS and CNA J. NHA A reported CNA J was giving Resident #81 a shower and she reported to the CNA she was glad her fungal/yeast infection were cleared up and she didn't like the wound care nurse coming and touching her. Resident #81 had informed CNA J she didn't feel comfortable with him touching me down there. NHA A reported the Unit Manager and the DON had come into the building to assess and begin investigation of the allegation. NHA A reported the Wound Nurse KKK was suspended that day, 7/12/25. NHA A reported on Monday, she called Wound Nurse KKK, and he had come in to talk to her and she wanted to get his statement. NHA A informed him of the allegation, and he immediately didn't want to say anything, he didn't want to talk unless he had representation, and he left the building. NHA A reported she reached out to him again for him to provide a statement, and he refused to participate in the investigation. NHA A reported she was informed he had obtained an attorney but had not provided a statement to the allegation to this date. NHA A reported as far as she knew the police investigation was ongoing as the detective reported to her, he was waiting for Wound Nurse KKK's attorney to contact the police and provide a statement. NHA A reported she had reached out to the Wound Nurse KKK again, and he did not respond. NHA A reported he was terminated from the facility. This writer attempted to contact Wound Nurse KKK, this writer did not hear from Wound Nurse KKK prior to exit of survey.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that PRN (as needed) psychotropic medications were limited to 14 days in 1 (Resident #12) of 5 residents reviewed for unnecessary medications.Findings include:Resident #12Review of an admission Record revealed Resident # 12 as a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: depression and anxiety disorder.Review of Physician Order for Resident #12 revealed Lorazepam oral tablet 0.5mg Controlled drug level 4, 1 tablet by mouth PRN every 4 hours start 8/12/2025 with an end date as indefinite.In an interview on 8/13/2025 at 1:14pm, Licensed Practical Nurse (LPN) D reported that PRN medications did not have to have a specific stop date unless the provider indicated a stop date.In an interview on 8/13/2025 at 1:16 pm Nurse Manager/Licensed Practical Nurse (NM/LPN) M reported that all PRN medications should be ordered for only 14 days unless a rationale was provided by the provider.In an interview on 8/13/2025 at 2:41 pm, Director of Nursing (DON) B reported that all PRN psychotropic medications should be prescribed for only 14 days at a time unless a rational was provided. When queried if Resident #12 had a documented rationale, she replied that the provider would document it. Requested the documented rationale from the provider.No documented rationale for Resident #12's Lorazepam oral tablet 0.5 mg, 1 tablet by mouth PRN every 4 hours, with no end date was provided by the time of exit.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2586142Based on interview, and record review, the facility failed to report 2 elopements and an allegation of abuse to the State Agency in a timely manner for 2 (Resident #73, Resident #66) of 3 residents reviewed for abuse and reporting, resulting in the potential for ongoing mistreatment, as well as additional incidents of elopements and alleged abuse to go unreported.Findings include: Resident #73 Review of an admission Record revealed Resident #73 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: parkinson’s disease (a disorder of the central nervous system that affects movement that may also cause hallucinations (sensory experiences that seem real but are created by the mind), metabolic encephalopathy (disorder that affects the brain’s function), weakness and anxiety (persistent state of worry). Review of a Minimum Data Set (MDS) assessment for Resident #73 with a reference date of 6/22/25, revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #73 was cognitively intact. Section “E” of the MDS revealed Resident #73 wandered 1 to 3 days during the assessment period. Section “GG” revealed Resident #73 required the use of a wheeled walker to safely ambulate. Review of a “Care Plan” for Resident #73 with a reference date of 1/6/25, revealed a focus/goal/interventions of: “Focus: (Resident #73) is an elopement risk/wanderer sundowner (phenomenon where those with cognitive impairments experience worsening of symptoms in the late afternoon or evening). Goal: The resident’s safety will be maintained…Interventions: exit and stairwell alarms…photo on wander list, staff aware of residents wander risk…wander ALERT personal safety device: Right ankle). In an interview on 8/11/25, at 2:26pm, Confidential Informant (CI) “DDD” reported they were caring for another resident in their room one afternoon, when they (CI “DDD”) looked outside and saw Resident #73 walking in the service driveway alone, without her walker. CI “DDD” reported this incident occurred “within the last few months”. CI “DDD” reported they ran outside and found Resident #73 alone, walking down the service drive, approximately 100’ from the emergency exit on her unit. CI “DDD” reported Resident #73 was not safe to leave the building alone because she was confused and lacked safety awareness. CI “DDD” reported LPN “MM” also responded to the situation and together they assisted Resident #73 back inside. CI “DDD” reported upon returning Resident #73 to the unit, she was approached by Nursing Home Administrator (NHA) “A” and DON “B” who instructed CI “DDD” not to document the incident in the electronic medical record (EMR). In an interview on 8/12/25 at 11:07am, LPN “MM” reported Resident #73 eloped from the building and was found alone, walking briskly down the service drive, approximately 100’ from the nearest exit. LPN “M” reported she was unsure of the date of the incident, but an incident report had been written. LPN “MM” reported she told NHA “A” Resident #73 had eloped and that the door alarm had been sounding for a few minutes, but she (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	didn’t recognize the sound of the alarm from behind a closed resident door. In an interview on 8/12/25 at 11:50am, Family Member (FM) “CCC” reported the facility called her on two separate occasions to report Resident #73 had eloped from the building. FM “CCC” reported the first elopement occurred shortly after the resident was admitted to the facility on [DATE] and again, “sometime in the last few months”. In an interview on 8/13/25 at 12:48pm, NHA “A” reported Resident #73 exited the building on 4/23/25. NHA “A” reported the incident was not submitted to the state agency because she thought the incident was witnessed by staff. When further queried, NHA “A” reported she did not have any signed, documented staff interviews related to the incident and was not aware of any documentation of the event in the resident’s medical records. Review of an “Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property” facility policy with a reference date of 11/28/17, revealed “PURPOSE:…The Nursing Home Administrator or designee will report “abuse” to the state agency per State and Federal requirements immediately…REPORTING AND RESPONSE:…The facility will ensure that alleged violations involving abuse…neglect…mistreatment…are reported immediately, but not later than 2 hours…”. Resident #66 Review of an “admission Record” revealed Resident #66 was a female, with pertinent diagnoses which included: Alzheimer’s Disease (a form of dementia) with late onset, psychotic disorder with delusions due to known physiological condition, and visual hallucinations. Review of a “Facility Report Incident” (FRI) incident report revealed, “…Details Type of Alleged Incident: Abuse…Date/Time Incident Discovered 1/26/25 05:00 PM…Facility Investigator: (“Former Nursing Home Administrator” (FNHA) “EEE”) .Incident Summary: (Resident #66) is a long term care resident with medical history of dementia and depressive and psychotic disorders and a social history of sexual abuse in her past. (Resident #66) makes statements that (visitor name omitted), the husband of another long term care resident, touches her inappropriately. On 1/26/25 (Resident #66) told her nurse (“Licensed Practical Nurse” (LPN) “ZZ”) that (visitor name omitted) molested her…Submitted Date/Time: 1/27/25 11:43 AM…” In an interview on 8/13/25 at 12:05 PM, “Nursing Home Administrator” (NHA) “A” reported abuse allegations must be reported within 2 hours to the State. In an interview on 8/13/25 at 12:26 PM, FNHA “EEE”, when queried as to why the FRI reported on 1/27/25 at 11:43 AM for Resident #66 had not been reported to the State Agency within two hours of the Date/Time Incident Discovered on 1/26/25 at 5:00 PM, FNHA “EEE” reported she did not remember the details of reporting the incident to the State. FNHA “EEE” confirmed an allegation of abuse should be reported within 2 hours to the State.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure a proper bedhold notification was completed for 1 resident (Resident #66) of 1 resident reviewed for hospitalization, resulting in Resident #66's not receiving a written notice of bedhold. Findings include:Resident #66Review of an admission Record revealed Resident #66 was a female, with pertinent diagnoses which included: Alzheimer's Disease (a form of dementia) with late onset, psychotic disorder with delusions due to known physiological condition, and visual hallucinations.Review of Resident #66's Census Screen in the electronic medical record revealed effective date 8/6/25, STOP BILLING.In an interview on 8/12/25 at 8:49 AM, Social Services Director (SSD) FF reported resident #66 was sent to a psych (psychiatric) hospital due to ongoing physical behaviors and hallucinations. In an interview on 8/12/25 at 2:41 PM, Nursing Home Administrator (NHA) A reported the facility did not have a behold for Resident #66 for her hospitalization and could not provide evidence that one had been provided to Resident #66.In an interview on 8/13/25 at 9:20 AM, Nurse Manager RN (NMRN) N reported when a resident is sent to the hospital, a bedhold should be sent with every resident or given to the family. In an interview on 8/13/2025 at 9:23 AM, Registered Nurse (RN) NN reported when a resident transfers to the hospital a bedhold should be given to the resident or provided to the family.In an interview on 8/13/2025 at 11:08 AM, NHA A reported the expectation was that the bedhold is sent with the resident when the resident goes to the hospital. NHA A reported since planning had gone into sending Resident #66 to the psychiatric hospital, there may had been some confusion on providing a bedhold for the particular situation. NHA A reported as a standard of practice, a bedhold should be provided when a resident is sent to the hospital. NHA A reported Resident #66 should have had a bedhold given to her.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan related to sexual behaviors for 1 resident (Resident #99) of 18 reviewed for care plans resulting in some staff being unaware of Resident #99's behaviors and sexual history.Findings include:Resident #99 (R99)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R99 admitted to the facility on [DATE] with pertinent diagnoses including spinal fracture and alcohol abuse. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R99 was cognitively intact (13 to 15 cognitively intact). R99 had a previous admission at the facility from 4/10/2025 to 4/23/2025.During an observation on 8/11/2025 at 8:18 AM, Certified Nursing Assistant (CNA) KK was sitting outside R99's bedroom door. CNA KK stated that R99 was on a 1:1 observation at all times for several days but she didn't know why. During an interview on 8/11/2025 at 8:38 AM, R99 stated that he was on 1:1 observation since he went into a resident's room (R100) the other day. While talking to this surveyor, R99 appeared to be stroking his genitals under his clothes. During an interview on 8/11/2025 at 8:31 AM, CNA RR said that she thought R99 was on 1:1 observation since he was inappropriate with a female resident.During an interview on 8/11/2025 at 8:37 AM, Licensed Practical Nurse (LPN) T stated that R99 was on 1:1 observation but she didn't know why. Review of R99's chart revealed a behavior note documented by Licensed Practical Nurse (LPN) LLL from a previous admission dated 4/14/2025 Location/Cause: Resident room, passing AM medication Behavior: Resident grabbing at nurses breast and groin, started fondling self. Description of behavior: sexually inappropriate. Behavior/Intensity: Non Pharmacological Interventions: spoke with resident stated I am your nurse and this is not appropriate to grab me.During a phone interview on 8/13/2025 at 12:28 PM, LPN LLL stated that the incident occurred when she was taking R99's vitals. LPN ?LLL said she told her supervisor about the incident and documented the behavior in a progress note. LPN LLL said that R99 was sexually inappropriate and was often seen touching his private area in his bed. During an interview on 8/11/2025 at 12:49 PM, Nurse Manager (NM) N stated that R99 was on 1:1 since 8/7/2025 since he was found in R100's room. NM N said R100 was next to his room and she was moved immediately afterwards.During an interview on 8/13/2025 at 8:14 AM, CNA CC stated that R99 was sexually inappropriate since admission. She said that R99 [NAME] off in his room all the time. During an interview on 8/13/2025 at 8:24 AM, RN NN stated that when she walked into R99's room several times he appeared to be masturbating. She also said he likes to brush up against staff but she hadn't observed any behaviors with residents. RN NN stated that management knew about R99's sexual behaviors since Wound Care Nurse (WCN) S told some staff to keep an eye on R99 since he was on the Michigan Sex Offender Registry List.During an interview on 8/13/2025 at 9:02 AM, WCN S reported that she knew R99 was on the Michigan Sex Offender Registry List since he came from another facility where she worked at. WCN S stated that some staff were aware of R99 being on the list and his behaviors since she told some CNAs and the nurse when she had to do a skin assessment on R99 upon his admission. Review of R99's chart revealed R99 being on the Michigan Sex Offender Registry List on 4/9/2025 at his previous admission.Review of 99's chart revealed he was still on the Michigan Sex Offender Registry List at the time of this admission on [DATE]. Review of R99's baseline care plan revealed no care plan for R99's behaviors and related to R99 being on the Michigan Sex Offender Registry List. Review of Social Services Evaluation completed on 8/7/2025 by Social Service Assistant (SSA) HH revealed . Screening for Abuse/Neglect.8. History of or presence of behaviors, such as provoking, aggressive manner, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention seeking, and/or otherwise abrasive/inappropriate behavior: Yes.9. History of mistreating others (i.e. verbal/physical/sexual/ financial exploitation) and/or information presented by a reliable source that indicates there is a history of mistreating (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	others: Yes During an interview on 8/13/2025 at 10:37 AM, Social Worker Director (SWD) FF and Social Worker Aide (SSA) HH stated that they were not aware of R99 being on the Michigan Sex Offender Registry List. Both SWD FF and SSA HH said that the team did not notify them of this. This surveyor stated that this information was available in R99's chart. They also stated that they were not aware of the incident between R99 and R100 on 8/7/2025 since they weren't part of the investigation, they only knew R99 had a 1:1 staff observation. When discussing that there was no baseline care plan in R99's chart regarding his behaviors, SSA HH said he was only at the facility for 6 days so a comprehensive care plan was not done. This surveyor mentioned that a baseline care plan must be done within 48 hours of admission and there was nothing in the care plan to indicate him being on the Michigan Sex Offender Registry List and the behaviors he was exhibiting with staff and the incident with R100. SSA HH acknowledged this. During an interview on 8/13/2025 at 10:44 AM, NHA A stated that she didn't know R99 was on the Michigan Sex Offender Registry List and this surveyor pointed out that it was in R99's chart. NHA A acknowledged that a baseline care plan was not completed regarding R99's behaviors. Resident #100Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R100 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS) reflected a score of 11 out of 15 which indicated R102 had moderate cognitive impairment (8 to 12 cognitively impaired).During an interview on 8/11/2025 at 12:56 PM, R100 stated that she didn't remember R99 being in her room. During an interview on 8/11/2025 at 12:56 PM, Family Member (FM) VV who was in R100's room at the time stated that she was at the facility when the incident occurred. She stated on 8/7/2025 she went to see R100 at night and noticed R99 in R100's room behind her sideways in his wheelchair and trying to talk to her and R99 said I don't care what corner we go to but I want to get in a corner with you. FM VV stated that she didn't see him touch her and she told R99 to leave the room and told nurse (LPN OO). FM VV said Nursing Home Administrator (NHA) A came into the facility that night and R100's room was moved per her choice instead of moving R99. Review of the Care Plan Standard Guidelines with an effective date of 11/28/2017 revealed .Baseline Care Plan: It is the practice of this facility to develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care. The baseline care plan will 1. Be developed within 48 hours of a resident/s admission. 2. Include the minimum health care information necessarily to properly care for a resident including but not limited to. e. social services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide timely ADL (activities of daily living) care for 1 resident (Resident #109) of 2 residents reviewed for ADL Care, resulting in Resident #109 not receiving timely incontinence care on 8/10/25 when a Certified Nursing Assistant (CNA) mistakenly thought the resident was independent with personal care. This deficient practice resulted in the potential for skin breakdown, feelings of embarrassment, and unmet care needs. Findings include: Review of an admission Record revealed Resident #109 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: aphasia following a stroke (language disorder that affects a person's ability to verbally communicate), weakness and hemiplegia (paralysis on one side of the body) following a stroke.Review of a Minimum Data Set (MDS) assessment for Resident #109 with a reference date of 8/11/25, revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated Resident #109 could not complete the assessment. Section GG of the MDS revealed Resident #109 needed partial assistance from staff for personal care.Review of a Care Plan for Resident #109 with a reference date of 7/30/25, revealed a focus/goal/interventions of: Focus: The resident has actual ADL self-care performance deficit r/t (related to) CVA (stroke).Goal: The resident's ADL needs will be met and anticipated by staff through next review. Interventions: Bed Mobility (ability to move self in bed): Max Physical Assist (helper performs more than half the effort) .Personal Hygiene: The resident needs physical assist. Review of a Kardex (general care guide) for Resident #109 revealed Skin: provide peri care after each incontinent episode.In an interview on 8/11/25 at 9:53am, Family Member (FM) QQQ reported on the night of 8/9/25 into the early morning hours, Resident #109's incontinence brief was not changed for several hours during the overnight. FM QQQ reported she stayed overnight with Resident #109 and did not see any staff come in for several hours. FM QQQ reported Resident #109 slept throughout the night and did not demonstrate any discomfort.In an interview on 8/12/25 at 9:11am, Certified Nursing Assistant (CNA) RRR reported she cared for Resident #109 on 8/9/25 until approximately 10:30pm when she was reassigned to provide 1:1 supervision to another resident. CNA RRR reported she provided a verbal report regarding Resident #109's care needs to CNA SSS. CNA RRR stated I told CNA SSS that Resident #109 was incontinent and would need assistance of 2 staff for incontinence care. CNA RRR reported CNA SSS came to her around 5:00am and told her she thought Resident #109 was independent with cares and had not checked on her. CNA RRR reported she went to Resident #109, who was sleeping, and found her wearing a heavily saturated incontinence brief. The pad under Resident #109 was also wet with urine. CNA RRR reported Resident #109 did not have any reddened skin on her peri-area but should have been changed sooner. CNA RRR reported she and CNA SSS provided incontinence care to Resident #109 at that time. CNA RRR reported she asked CNA SSS why she had not provided the care earlier and CNA SSS reported she had mistaken Resident #109 with the resident in the next room, who was independent. When queried about how staff knew about resident care needs, other than by staff-to-staff verbal reports, CNA RRR reported the staff used a communication board that outlined resident care needs, but because of the format of the board, it was easy to mix up the information.In an interview on 8/12/25 at 9:06am, CNA P reported she provided incontinence care for Resident #109 at approximately 7:00am on 8/10/25. CNA P reported the resident's brief was wet, but the urine was contained within the brief, and the resident had no reddened skin in her peri-area.Efforts to contact CNA SSS were unsuccessful by the conclusion of the survey.Review of an Activities of Daily Living (ADL'S) facility policy with a reference date of 5/7/20 revealed In accordance with the comprehensive assessment, together with respect for individual resident needs and choices our facility provides care and services for the following activities: hygiene.elimination.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that follow up with pharmacy recommendations occurred for 1 resident (Resident #57) and monitoring of side effects of psychotropic medications (any medication that affects the mind and alters mental processes such as antidepressants, antipsychotics, anxiolytics, sedatives and stimulants) occurred for 2 residents (Resident #57, Resident # 64) of 5 residents reviewed for medications resulting in the potential for unnecessary medications and no monitoring and follow-up of potential side effects of medications.Findings include:Resident #57 (R57)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R57 admitted to the facility on [DATE] with pertinent diagnoses including schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly and is characterized by thoughts or experiences that seem out of touch of reality, disorganized speech or behavior and decreased participation in daily activities), dementia (impairment in brain function such as memory loss and judgement), bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), anxiety and hypothyroidism (thyroid gland doesn't produce enough thyroid hormone which can lead to slowing down of the body's metabolism) . Brief Interview for Mental Status (BIMS) reflected a score of 8 out of 15 which indicated R57 had moderate cognitive impairment (8 to 12 cognitively impaired).Review of the Consultant Pharmacist Recommendation to Prescriber dated 4/23/2025 and also on 6/26/2025 revealed Comment: (R57) receives Synthroid 150 mcg (micrograms) and had a recent TSH level (thyroid stimulating hormone) of .26 on 3/7/2025. Recommendation: Please consider decreasing Synthroid to 137 mcg daily. If a dose change is made, please obtain a follow up TSH and free T4 level (free thyroxine) 6 weeks from titration. The order wasn't changed until 7/4/2025. The physician agreed and signed the form on 8/11/2025.Review of R57's physician order history for levothyroxine (synthroid) for hypothyroidism revealed .levothyroxine Sodium Oral Tablet 150 mcg (Levothyroxine Sodium). Give 1 tablet by mouth in the morning for hypothyroid Give on an empty stomach at least 1/2 hr (hour) before eating, start date of 11/22/2024 and an end date of 7/3/2025. Levothyroxine sodium 137 mcg give1 tablet by mouth in the morning For hypothyroid. Give on an empty stomach at least 1/2 hr before eating, start date of 7/4/2025.Review of R57's physician orders revealed Haloperidol Oral Tablet 5 MG (Haloperidol). Give 1 tablet by mouth three times a day for delirium/bipolar disorder with a start date of 11/21/2024. There was no order for monitoring for signs/symptoms of this medication. Resident #64 (R64)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R64 admitted to the facility on [DATE] with pertinent diagnoses including type 2 diabetes and depression. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R64 was cognitively intact (13 to 15 cognitively intact).Review of R64's physician orders revealed Venlafaxine HCl (hydrochloride) ER (extended release 150 MG (milligrams) Capsule extended release 24 hr (hour). Give 150 mg by mouth one time a day for re (regarding): depression. There was no order for monitoring for signs/symptoms of this medication. During an interview on 8/12/2025 at 9:16 AM, Licensed Practical Nurse (LPN) I stated that there was a question in R57's orders for the nurses to answer if there were any signs/symptoms of her haloperidol. LPN I went into the chart and she couldn't find the question where they had to click on yes or no if they saw any signs or symptoms of the medication for every shift. LPN I said if she noticed any signs and symptoms with R57's medication she wouldn't be able to document them in the orders and would have to document it somewhere else. When discussing R64, LPN I stated that there wasn't an order to monitor for sign and symptoms of his antidepressant either and she wouldn't be able to document them in the orders and would have to document it somewhere else. During an interview on 8/13/2025 at 1:30 PM, Registered Nurse (RN) NN stated that any resident on a psychotropic should have an order to monitor for sign and symptoms of that medication.Further (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of R57's and R64's chart revealed that there was no documentation of monitoring their psychotropic medications.During an interview on 8/12/2025 at 4:30 PM, Social Worker Director (SWD) FF and Social Worker Aide (SSA) HH stated that they document in the care plan to monitor signs and symptoms of any psychotropic medication but the nurses are responsible for putting the order in the chart and monitoring for signs/symptoms of the medication. SWD FF could not find the order for monitoring of the antipsychotic medication for R57 or the antidepressant for R64. During an interview on 8/13/2025 at 1:21 PM, Nurse Manager (NM) N stated that there should be an order for monitoring signs and symptoms of psychotropic drugs for all residents on them. NM N verified there wasn't an order to monitor for signs/symptoms of R57's antipsychotic or R64's antidepressant. During an interview on 8/13/2025 at 1:38 PM, Director of Nursing (DON) B stated that the process for monthly pharmacy reviews was that the pharmacist emails the monthly recommendations to her and she prints it off and it gives it to the provider and they fill out whether they agree or disagree with the recommendations. DON B said sometimes the provider will put the order in and sometimes she will. When discussing monitoring for signs and symptoms of psychotropic medications, DON B said there should be an order for monitoring all psychotropic medications and that R57 should have had an order for monitoring her haloperidol and R64 should have had an order for monitoring his venlafaxine. Review of the Psychotropic Medication Management Policy with an effective date of 11/28/2017 revealed .Psychoactive Medication data Collection Procedure.16. Appropriate monitoring for mood/behavior/sleep, along with monitoring for side effects and medication efficacy, will be reviewed and/or initiated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, interview, and record review the facility failed to 1). properly store medications in a secure manner in 2 of 6 medications carts: 2). ensure the interior of medication carts were clean: 3). ensure that medication refrigerators were secured with a lock: and 4). ensure consistent monitoring and documentation of refrigerator temperatures occurred.Findings include:On 8/12/2025 at 8:35 am, Registered Nurse (RN) PPP was observed placing into locked narcotic box on the medication cart for part of the flower unit, a medication cup with one white pill, which she placed tape over the top of the cup, wrote a resident's name on it before placing in the narcotic box and locking the box back up.In an interview on 8/12/2025 at 8:35 am, RN PPP reported the resident refused the pills she placed into the narcotic box. RN PPP reported she would need to waste the pill with another nurse as it was a hydrocodone (Norco) tablet.On 8/12/2025 at 8:57 am, Licensed Practical Nurse (LPN) P was observed placing into the top drawer of the enchanted medication cart a medication cup with two pills in it. LPN P closed and locked the cart and walked away. At 9:00 am, LPN P was observed when she returned to the medication cart, unlocked the cart and withdrew the medication cup with the two pills in it and continued to dispense other pills into the cup.On 8/12/2025 at 10:01 am, RN PPP was observed unlocking, opening the top drawer of the medication cart on the flower unit and retrieving three medication cups, one with liquid in it and two others with loose pills in them. RN PPP was then observed dispensing a narcotic from the lock box into one of the cups of pills and entering a room to administer the medications to a resident.In an interview on 8/12/2025 at 10:01 am, RN PPP reported she did not wait the narcotic medication she stored in the medication cart lock box earlier, RN PPP reported she administered it to the resident it was intended to be given to earlier.On 8/12/2025 at 9:57 am, the medication cart on the tea unit was noted to have a white saltlike substance spilled in the bottom of the drawer on the right bottom of the medication cart. Tour of the medication room on the unit revealed missing entries on to the refrigerator temperature logs.On 8/12/2025 at 10:08 am, the medication cart on the flower unit was noted to have liquid medication spillage in the bottom right drawer, and a blue in color bottle noted to have white streams of dried crusted liquid down the side of it in the third drawer in the middle down on the medication cart. RN PPP was observed removing the blue in color bottle and placing it into the trash can on the side of the medication cart and stating, this probably needs to be thrown away, this resident isn't here any longer.On 8/12/2025 at 2:03 pm, the medication cart on the heirloom unit was noted to have liquid medication spillage in the drawer on the bottom right of the medication cart. Tour of the medication room on the heirloom unit it was noted the refrigerator was unlocked and the refrigerator temperature log was missing entries.In an interview on 8/12/2025 at 10:47 am, LPN T reported she had not been in the medication room that day during her shift and she was unaware the refrigerator was unlocked. LPN T reported the refrigerator did not need to be locked as there were no narcotic medications in it.In an interview on 8/12/25 at 2:39 pm, Nurse Manager/Licensed Practical Nurse (NM/LPN) M reported that medications should be clean. NM/LPN M reported dispensed medications should not be stored in the drawers of the medication carts. If not administered the medications should be destroyed and re-dispensed if needed. NM/LPM M reported that refrigerators in the medications room should be locked at all times unless the nurse was getting into it and the refrigerator should have the temperature checked and recorded on the log once a shift.In an interview on 8/12/2025 at 2:51 pm, RN PPP reported it was fine to place the dispensed narcotic medication back into the lock box in the medication cart when a resident refuses to take it when it was dispensed. RN PPP stated it was safe, it was labeled, and it was fine to store (the Norco) in the cart until the resident wanted it.In an interview on 8/12/2025 at 2:55 pm, LPN T reported dispensed medications in medication cups should not be stored in the top drawer of the medication cart. The medications should be taken with the nurse or destroyed.In an interview on (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/12/2025 at 2:58 pm, Nurse Manager/Registered Nurse (NM/RN) N reported the refrigerator in the medication room should be locked at all times, and the temperature of the refrigerator should be logged on the temperature log every shift. NM/RN N reported dispensed medication in medication cups should not be stored in the top drawer of the medication cart.In an interview on 8/12/2025 at 3:02 pm Director of Nursing (DON) B reported dispensed medications should not be stored in medication cups in the top drawer of the medication cart. DON B reported the refrigerator in the medication room should be locked at all times unless a nurse was getting something out of it. Review of Refrigerator Temperature Log for the tea unit medication room refrigerator revealed 10 blank entries in July and 6 blank entries in August; Temperature log for the enchanted unit medication room refrigerator revealed 5 blank entries for both July and August; Temperature log for the flower unit medication room refrigerator revealed 25 blank entries in July and 7 blank entries for August; The temperature log for the heirloom medication room refrigerator revealed 4 blank entries for July and 13 blank entries for August.Review of facility policy Persona Food Guidelines with a revision date of 2/7/2025 revealed .all refrigerators will be at or below 41 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician ordered enhanced barrier precautions for 2 of 3 residents (R2 and R41) reviewed for infection control, resulting in the potential for the spread of infection to a vulnerable population. Findings include: Resident #2 (R2) Review of an admission Record revealed R2 was a [AGE] year-old female, originally admitted to the facility on [DATE] with pertinent diagnoses of a stroke causing left sided weakness and paralysis and a pressure wound on her coccyx. Review of a Brief Interview for Mental Status (BIMS), dated 08-13-25, revealed a score of 15 out of 15 which indicated R2's cognition was intact. During an observation on 09-17-25 at 10:15 AM, the door of R2's room had a sign posted that alerted staff and visitors that R2 required Enhanced Barrier Precautions (EBP) for certain close contact interactions. Review of a physician Order Summary for R2, reflected an order for Enhanced Barrier Precautions (EBP) with a start date of 02-25-25. During an observation on 09-17-25 at 12:12 PM, Certified Nurse Aide P provided peri-care to R2 and did not wear a gown.During an interview on 09-17-25 at 12:38 PM, R2 stated that when staff came into her room to provide cares, they did not usually wear gowns. During an interview on 09-18-25 at 1:24 PM, Certified Nurse Aide (CNA) F stated that when a resident was on EBP, the minimum PPE required were a gown and gloves for all cares. Resident #41 (R41) Review of an admission Record revealed R41 was an [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of dementia, weakness, and repeated falls. During an observation on 09-17-25 at 1:15 PM, the door of R41's room had a sign posted that alerted staff and visitors that R41 required Enhanced Barrier Precautions (EBP) for certain close contact interactions. Review of a physician Order Summary for R41 reflected an order for Enhanced Barrier Precautions (EBP) with a start date of 02-17-25. During an observation on 09-17-25 at 1:30 PM, R41 sat in her bathroom on the toilet, with the call light on. SCNA II responded to the call light at 1:40 PM and assisted R41 off the toilet and into her wheelchair without the use of a gown. During the same observation, CNA II transferred R41 from the wheelchair to her bed without the use of a gown and gloves. Review of the facility policy Personal Protective Equipment Guideline last revised 04-12-24, reflected the following direction for staff to follow when caring for a resident on EBP: Enhanced Barrier precautions expand the use of PPE (personal Protective equipment) and refers to the use of a gown and gloves during high-contact resident care activities that provide opportunities to transfer MRDO's (multi-drug resistant organisms) to staff hands and clothing. MDRO's may be indirectly transferred from resident to resident during these high-contact care activities.