STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235292	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste. Marie	1011 Meridian Road Sault Ste. Marie, MI 49783

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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 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2702621.Based on observation, interview, and record review, the facility failed to ensure adequate staffing to promote the highest possible level of physical, mental, and psychological well-being for all 86 residents of the facility as evidenced by:Failure to ensure assistance with activities of daily living (ADLs) including routine incontinence care, bathing, shaving, turning and repositioning, and feeding.Failure to accommodate resident preferences including sleep/wake schedules, treatment times, and physical location within the facility.Failure to ensure a timely, dignified, and palatable meal service.Failure to maintain a restorative therapy program.Failure to respond to call lights within an appropriate time frame.These deficient practices resulted in harm when:Residents #4, #93, and #75 were forced to lay in her own excrement and urine for an extended period resulting in reported feelings of frustration, helplessness, humiliation, and anger and/or inference of these feelings based on the reasonable person concept.Resident #10 was forced to lay in bed for an extended period resulting in excruciating pain.Resident #91 experienced ongoing feelings of fear and panic following lack of staff response for over two hours after activation of a call light.Findings include:During an interview on 2/8/26 at 3:26 p.m., Licensed Practical Nurse (LPN) X reported There are never enough Certified Nurse Aides (CNA's) and they work short all the time. Resident #15 (R15) During an interview on 2/8/26 at 3:26 p.m., R15 stated I am scared to be here due to the lack of staffing. There are times when I can't reach my call light. What if I need some help and no one is here to help me. I don't want to die. I am petrified every day because I worry there will be no one to help me. During an interview on 2/10/26 at 2:23 p.m., CNA F reported Staffing here is awful, there are times when we can't take care of the residents. They don't get the care they deserve and they are being neglected. I was so glad when you came in on Sunday and we only had three CNAs. That is what it is like all the time. The management are never out here helping us. If people call in, they don't replace that person. The residents deserve better. We try to reposition people every two hours but with the lack of staff it is not possible. Resident #4 During an observation and interview on 2/8/26 at 2:27 p.m., prior to entering R4's room the smell of urine and feces emanated out into the hallway. R4 asked for the door to be closed. The smell of urine and feces permeated the room. Feces was noted on the pillowcase, and sheet that was partially covering R4. Feces was smeared on the fitted sheet and the fitted sheet was not around the mattress, as feces was noted on the mattress. R4's hands were lying on the top of a sheet with (continued on next page)

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

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F 0725 Level of Harm - Actual harm Residents Affected - Some	brown matter under her fingernails and on her hands. R4 reported she had not gotten out of bed yet today. R4 was visibly shivering. During an observation and interview on 2/8/26 at 2:48 p.m., R4 was yelling out for help while visibly shaking and reported, I am soaking wet.I wish someone would come and change me.I am so cold. During an observation on 2/8/26 at 2:56 p.m., R4 was yelling from her room, Please help me, Oh God please! with no staff visible in the hall. During an observation on 2/8/26 at 3:11 p.m., LPN/Unit Manager W walked into R4's room and quickly exited. LPN W said out loud to herself [Residents name] wants to get up. LPN W continued to walk down the hallway and did not return to assist resident. During an observation on 2/8/26 at 3:16 p.m., R4 continued yelling Nurse please help me. During an interview on 2/8/26 at 3:18 p.m., CNA L was queried about R4 and when she last received care. CNA L reported I honestly couldn't tell you. During an observation and interview on 2/9/26 at 4:20 p.m. R4 was yelling for help from her room. Upon entering her room, the smell of urine permeated the room. R4 was shivering in her bed. R4 stated I am so cold, I am so full of piss and I am so wet.would you please come and help me? I told that little nurse and she has not come in to help me. R4 had tears [NAME] up in her eyes and coming down her cheeks and stated, I am so tired of not being cared for, they don't take care of me here. I am from this town and I want to get the hell out of this place. I don't want to be here. I don't want to die here like this. During an interview on 2/9/26 at 4:28 p.m., the Senior Director of Nursing (DON) CC and the Director of Nursing (DON) were notified of R4 yelling for help. During an interview on 2/11/26 at 9:38 a.m., the Nursing Home Administrator (NHA) acknowledged concern regarding resident sitting in urine, feces, and shivering and the need for nursing care for resident. Review of policy titled Abuse, Neglect, and Exploitation date reviewed/revised 1/10/24, read in part .Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Resident #91 (R91) The facesheet for R91 had an original admission to the facility on 2/6/26. According to R91's Minimum Data Set (MDS) dated [DATE], a Brief Interview for Mental Status (BIMS) score of 15/15 indicated R91 was cognitively intact. On 2/8/26 at 2:33 PM, R91 provided a notebook where she had been writing about her experience at the facility since her admission on [DATE] at approximately 6:20 PM. R91 had written she was told dinner was on the way and at 7:15 PM still did not get dinner on 2/7/26. During her arrival staff scurried in, did a few things and flew back out of her room. R91 stated, I had no idea what was (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	happening with the staff and there I was just lying in bed. No vital signs were taken at the time of my admission, no blood pressure, no assessment or anything else. I needed pillows to elevate my legs to prevent bed sores and reduce swelling. I just sat there in total silence. R91 made a note she had put her call light on during Friday night and it was on for quite a spell. R91 noted that no staff came for quite some time and she was scared and upset over having to stay at the facility. R91 laid in bed wondering if something happened at the facility. R91 was unable to move because of the recently broken leg she was admitted to the facility with. R91 felt helpless as her call light continued to be on without being answered. R91 then got her cell phone out and looked up the phone number to the facility after she thought about calling the police. R91 called the facility, the phone was answered but not by staff. R91 stated, The facility phone had been answered by a resident was living at the facility. I could not believe another resident had answered the phone. It was a female resident who remarked 'it's for you' and the phone was handed over to a male resident, who promptly asked 'who is this?'. That was the last straw! I was completely thrown off guard and lost it. I really thought there was an emergency somewhere in the building or it had been taken over! What a mess! Finally, a female staff came to my room, and I told her what had just happened with the phone and the female staff person just looked at me with a blank look. I gave the female staff a chance to answer me and the staff finally said 'wow, I could not make that story up if I wanted to.' I agreed. I put my call light on in the early morning of 2/9/26 at approximately 2:00 AM and it was not answered until 55 minutes later to help me to the bathroom. During an interview on 2/9/2026 at 11:00 AM, R91 was observed in her bed and said, I got here Friday and Saturday I did not get any lunch and today (2/8/26) I did not get breakfast. It is now lunch time. I am not even sure I will get lunch. They treat animals at the zoo better than this! R91 voiced concerns with long call light wait times 1.5 to 2 hours, low staffing, and not seeing any staff for extended periods of time. R91 stated she needed ice for her surgical wound on her right leg after falling a fracturing it at home and no staff brought her ice. Resident #93 (R93) The facesheet for R93 had an original admission to the facility on 1/29/26 with diagnoses including fracture of the left tibia/fibula (both of the lower leg bones were broken). According to R93's MDS dated [DATE], a BIMS score of 15/15 indicated R93 was cognitively intact. R93 was evaluated as dependent on staff for bathing, requiring the assistance of two staff personnel, and for toileting was a one-person assist. During an interview on 2/9/26 at 12:10 PM, R93 voiced, yesterday morning she had been left wet and soiled in her urine and fecal matter for an extended period of time that lasted over two hours. R93 described the experience as mortifying and it felt nasty. On 2/10/26 at 2:15 PM, an interview was conducted with R93 and was asked about personal hygiene and replied, I have not received a shower since I got here, and I have been here for two weeks. The staff hardly get me up in my chair. R93 was observed at the time to have disheveled hair. R93's preferences for customary routine and activities, dated 1/29/26 revealed it was very important to her to be able to choose between a tub bath, shower, bed bath, or sponge bath and chose to have showers. On 2/9/26 at 8:55 AM, an interview was conducted with CNA V, who was asked if R93 had received (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	any showers since being admitted to the facility on [DATE] and replied, No, I do not have any shower sheets for her. Her (R93) shower days are Wednesday and Saturday. A lot of the times no showers are completed on Saturday because of call-ins. R93's task list for showers dated 1/29/26 through 2/10/26 were reviewed and revealed R93 did not receive a shower on 1/31/26 (Saturday), 2/4/26 (Wednesday), or 2/7/26 (Saturday). Resident #10 (R10) According to the medical record, R10 was admitted on [DATE] with diagnoses including spastic quadriplegic cerebral palsy (the most severe form of cerebral palsy characterized by extreme muscle stiffness and poor motor control in all four limbs and trunk), need for assistance with personal care, major depressive disorder and chronic pain syndrome. R10's MDS dated [DATE] contained a BIMS score of 15 of 15, indicating intact cognition. R10's functional status assessment revealed substantial assistance from staff to roll right or left, total dependence on staff to sit from lying down and total dependence on staff to transfer to and from a bed to a chair (or wheelchair). On 2/8/2026 at 2:34 PM, a sign was observed on the outside of R10's door which read, Please wake up by 1 PM. The room was dark and R10 was lying awake in bed. R10 stated, No one has been in yet. I like to get up by 1 (PM) and it is now 2:35 [PM]. During an interview on 2/9/2026 at 2:00 PM, R10 confirmed her desire to get up by 1:00 PM. She stated again she was not up until way after 1:00 today. She said she felt it was because there were not enough staff to help the residents. R10 said, They need more help here. R10 said it was very frustrating that almost every weekend there was not enough staff to provide care. When asked if she had told anyone her concerns, she stated she had told management multiple times, but nothing had changed. During a telephone interview on 2/9/2026 at 3:18 PM, CNA R said, I feel really terrible but there were not enough people to provide quality care yesterday. She repeated, I feel really bad. CNA R said R10 was supposed to get up by 1:00 and she did not get up until 3 yesterday. CNA R said, She needs two people to get her up and going and there were only 4 CNAs in the building so we could not get to her. The observed workload for 2/9/26 revealed one of the four CNAs was assigned to care for one resident at all times so the remaining three CNAs were responsible for the other 85 residents. The grievance log was reviewed and R10 had submitted multiple grievances to the facility to alert them of her staffing concerns. On 10/28/25 R10 submitted a type-written grievance to the facility. It read: My concerns: Not having enough staff & having nurses toilet me and put me to bed Not having enough staff in general for example today I'm sleeping in my wheelchair because after 10am there are only 3 certified aides & you can be the best aide but it's hard to take care of so many residents & I have minimal pain in my wheelchair. Just recently I didn't get up until 4pm & got a blister now I can't say it's all from that but I bet it's a (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	factor. Here's what I heard happened that day, the aide was going to get me up at 1:30pm the nurse told them to wait because the nurse wanted to go to lunch & then the hall got really busy & by the time they got to me it was 4pm. My pain level by then was a 9 & I was asked why I didn't hit the call light, well because I was sleeping because when I'm in pain I don't' cry I sleep I like to say it's a kin to passing out. That's why I need to be woken up. Some aides don't wake me up between 1pm & 2pm Some aides don't help out other aides Some aides don't ask for help. The facility response to this grievance: Findings: Resident states staff is not adhering to her wake up times and schedule. See attached letter Plan/Actions: Ensure that staff adheres to wake up times and schedule Describe: We have 6 new CNA's on the floor. Educated staff on wake up times On 1/6/2026 R10 submitted a type-written grievance to the staff during her care conference. It read: To whom it may concern; On Saturday December 27th the nurse asked me if I could wait until they (nurse & aide) went to lunch & I said NO because it was already after 2pm now they were short staffed & apparently the aide could not find help right then. But that doesn't mean that they can just go ahead and go to lunch anyway at least not without asking another aide to get me up while they are gone. I didn't get up until after 3pm and I was in a lot of pain because of it. I don't know if the aide needs better time management or something else but I can't lay in bed for like 10 hours my butt and back hurt. They can even get me up as early as 10 am and I will nap in my wheelchair as long as I'm not in bed for that long I'm good. I'm flexible but only up to a point. So please take care of this thank you, (signed R10) Resident #83 (R83) On 2/8/2026 at 2:50 PM, an observation of R83 revealed she was sitting in a reclined position in bed with her meal tray in front of her. R83 said she had just finished lunch and was fed by staff. When asked about her left contracted hand, R83 stated the staff do not work with her on it, and she is supposed to have a brace on but it is the weekend, so nothing is happening. On 2/10/2026 at 12:37 PM, R83 stated she was not getting restorative therapy and had not had it for a long time. R83 stated she was supposed to have a splint for her hand, and she needed assistance putting it on. R83 said, They (staff) do not put it on enough. During an interview on 2/10/2026 at 12:34 PM, CNA TT stated, the Restorative Aide put on the splints and did the restorative programs. CNA TT said, The CNAs do not do restorative unless we have time, and we don't usually have time. During an interview on 2/10/2026 at 12:36 PM, CNA J said there was a Restorative Aide who did (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Restorative. CNA J said, the CNAs did not do Restorative. According to the medical record, R83 was admitted on [DATE] with medical diagnoses including quadriplegia (paralysis affecting all four limbs and the torso), anoxic brain damage (damage from a shortage of oxygen to the brain), and need for assistance with personal care. R83's Minimum Data Set (MDS) dated [DATE] contained a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating intact cognition. R83's functional status assessment revealed total dependence from staff to roll right or left, total dependence of staff to lie down from sitting, and total dependence on staff to sit from lying down. Section O of the MDS also noted in the last 7 calendar days only one day had at least 15 minutes of passive range of motion (ROM) recorded and one day of splint or brace assistance. The medical record included the CNA task list for documentation of treatment as given. The most recent 14-day period was reviewed. For the task: Maintenance Restorative Nursing: Splint/Brace Assistance (12h) [NAME] palm protector splint to left hand for 3-4 hours of wear time. Check skin after doffing for redness or irritation. There were only two days when brace toleration was documented. All other days were documented as Did not occur. During an interview on 2/10/2026 at 12:58 PM, the Director of the Therapy Department/ Staff UU described the interaction between the therapy department and the nursing department. Staff UU reviewed her documentation and stated R83 was on the restorative list. During an interview on 2/10/2026 at 1:20 PM, Senior DON CC stated the facility was reorganizing their staff. DON CC said, We just got people in their roles in the past six months. We do not have a Restorative Nurse yet only a Restorative Aide. The Restorative Aide position was explained as a Monday – Friday position. DON CC stated the restorative program should be happening 7 days a week. When asked about the Restorative Aide, DON CC stated she currently had a medical incident and could not work. When asked who completed the restorative tasks on the weekend or when the current Restorative Aide was off, DON CC replied No one. Resident #75 (R75) Review of the MDS assessment, dated 1/20/2026, revealed R75 was admitted to the facility on [DATE] and had diagnoses including osteoarthritis, presence of an artificial knee joint and difficulty in walking. Further review revealed R75 required substantial/maximal assistance with transfers and was dependent on staff for toileting hygiene. R75 scored 12 out of 15 on the BIMS, indicating moderate cognitive impairment. On 2/08/2026 at 12:35 p.m., revealed LPN W was observed entering R75's room to assist the Resident's roommate. R75 was heard asking LPN W for assistance in getting cleaned up and out of bed for the day. LPN W informed R75 that she would attempt to find an aide to assist R75 and proceeded to leave the room. At that time, R75 was observed seated in bed wearing pajamas. A clean brief and clean clothing were observed to be folded atop the end of the Resident's bed. R75 reported she liked to be up in her wheelchair for the day and added, But I'm heavy and hard to get up. When asked if her brief was dry or if she needed assistance with incontinence care, R75 was observed reaching under the blanket to check her brief, then stated oh, well, yes, they will come eventually. During the observation, LPN W re-entered R75's room with a meal tray. After setting up the meal tray on an overbed table and placing it in front of R75, LPN W told the Resident, After you're done, we will come get you up and dressed. No incontinence care was offered or completed at the time of the (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	day, no water brought to him. 7/25/25: Resident reported not seeing a CNA in her room until 4 PM. Reports not being checked on unless using call light. 8/25/25: Call light on over 45 minutes. 9/27/25: Resident stated that aide did not let her stay in bed after lunch per her per preference. Stated aide told her that there were not enough staff to keep getting her in and out of bed. 10/1/25: Resident voiced to CNA that she was tired and that she hadn't been put to bed until 2 AM last night. Resident said that she had been asking to go to bed for hours. 10/13/15: DPOA [durable power of attorney] states very long call light times, especially at night. States she has had to come up here [to the facility] in the middle of night to toilet or change her mother. 10/15/25: Resident says he hasn't gotten out of bed in 4-5 days. Feels like he is being ignored. Staff tell him they will come back to help, but never do. 10/21/25: Concerns about staffing on D-wing, feel she should not have to stay late taking care of her mom. Is worried that she will not get the care she needs. 10/28/25: My concerns: Not having enough staff. for example today I'm sleeping in my wheelchair because after 10 AM they're only 3 certified aides. just recently I didn't get up [out of bed] until 4 PM. 11/18/25: Spoke with family here [sic] are their concern: soars [sic] on coccyx. Redness between his legs. Personal hygiene not being done in the evens [evenings]. Long wait time at night after turning on call light. 11/19/25: Resident reported that this morning, aids came into room to change roommates diaper, waking her up. Resident was wet, and was not checked on, turned on call light, and sat for an hour in urine soaked clothes. Resident feels neglected. 12/3/25: Dec [December] 2nd I asked the CNA if they could put my dad to bed at 6:50 PM. The other CNA told me they would be right there. They finally showed up at 7:45 [PM] to take him to the bathroom. in bed at 8:20 PM. 1/6/25: On Saturday December 27th the nurse asked me if I could wait [to get out of bed] until they (nurse & aide) went to lunch & I said NO because it was already after 2pm now they were short staffed & apparently the aide could not find help right then. I didn't get up until at 3 PM and was in a lot of pain because of it. I can't lay in bed for like 10 hours my butt & back hurt. The Plan/Action box on the Quality Assistance Forms contained the following written responses as solutions: staff education (9 times), developed plan for call-ins (1), moved resident room (1), higher priority resident needed help more (1), the facility has adequate staff (1), resident happy with care (1), left blank (1). Ten out of 15 forms were marked as resolved. Five out of 15 forms were left blank in the resolution section (neither 'yes' or 'no' had been selected). (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Review of a document titled, Caring Partner Concerns/Comments, dated 6/20/25, read, in part: He [resident] states he turns his call light on because he has to be changed [into a clean brief]. CNA comes in and turns light off and leaves room. Says they leave him laying in [expletive]. No resolution was found in relation to this concern. Review of the Facility Assessment, reviewed 9/16/25, revealed an average daily census of 72, ranging from a minimum 64 residents to a maximum of 78 residents. Review of census numbers from 10/1/25 – 2/11/26 revealed 90 days the facility census exceeded the maximum census (78 residents) outlined by the facility assessment. The highest census during this timeframe was 87 residents on 2/6/26. Further review of the facility assessment revealed 35.5% and 34.1% of resident admissions and discharges, respectively, occurred on Friday-Sunday. Review of night shift (6:00 PM – 6:00 AM) schedules between Friday-Sunday from 7/1/26 – 9/30/26 (quarter 3), revealed 17 days when 4 or fewer CNAs were working when a census ranged between 73-82 residents: 7/4/25: 3.5 CNAs – census of 75 7/5/25: 4.12 CNAs – census of 75 8/29/25: 4 CNAs - census of 73 8/31/25:

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F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2702621Based on observation, interview, and record review the facility failed to provide routine incontinence care for one Resident #4 (R4) of two residents reviewed for incontinence care. This deficient practice resulted in harm including anger, frustration, helplessness, and sadness based on the reasonable person concept.Findings include: On 2/8/2026 at 1:55 PM a foul odor was noted while standing near the doorway of R4's room and R4 could be heard calling out Nurse? Nurse? Upon entering R4's room, R4 was observed lying in a fetal position in bed with her bottom sheet pulled off the mattress and gathered around her and a top sheet draped over her torso and lower body. Upon approaching the bed, an overpowering smell of urine and feces was noted. R4 reported she was waiting for staff to come assist her to clean up. R4 reported she was cold and stated, I peed myself. R4 was asked if she had used her call light to call for assistance, which was observed to be attached to the left upper grab bar of her bed. At 1:57 PM R4 was observed to push the red call button to activate a call for assistance. Upon immediately exiting R4's room, it was noted the light above R4's door was lit, indicating activation of the call light. While this surveyor remained directly outside R4's room, an unidentified male staff person was observed entering R4's room. R4 was heard informing the staff person of her need to be cleaned up and that she was cold. The male staff person deactivated R4's call light as indicated by the light above her door being turned off and was heard telling R4, let me see if I can get an aide for you. The male staff person then immediately left R4's room and travelled toward the nurse's station at the end of the hallway. Further observation from the hall outside R4's room, revealed no staff entered R4's room and at 2:26 p.m. R4 was heard calling out, Nurse? Nurse? Upon re-entering R4's room it was noted the smell of urine and feces remained and R4 was observed lying in bed with her bottom sheet gathered around her and the top sheet draped over her torso and lower body. R4 was asked if anyone had come to assist her to which she answered no and further reported, I'm so cold. It was noted 29 minutes had elapsed from the time R4 activated her call light at 1:57 p.m. During an observation and interview on 2/8/26 at 2:27 p.m., prior to entering R4's room the smell of urine and feces emanated out into the hallway. R4 asked for the door to be closed. The smell of urine and feces permeated the room. Feces was noted on the pillowcase, and sheet that was partially covering R4. Feces was smeared on the fitted sheet and the fitted sheet was not around the mattress, as feces was noted on the mattress. R4's hands were lying on the top of a sheet with brown matter under her fingernails and on her hands. R4 reported she had not gotten out of bed yet today. R4 was visibly shivering. During an observation and interview on 2/8/26 at 2:48 p.m., R4 was yelling out for help while visibly shaking and reported, I am soaking wet.I wish someone would come and change me.I am so cold. During an observation on 2/8/26 at 2:56 p.m., R4 was yelling from her room, Please help me, Oh God please! with no staff visible in the hall. During an observation on 2/8/26 at 3:11 p.m., Licensed Practical Nurse (LPN)/Unit Manager W walked into R4's room and quickly exited. LPN/Unit Manager W and said out loud to herself [Residents name] wants to get up. LPN/Unit Manager W continued to walk down the hallway and did not return to assist resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an observation on 2/8/26 at 3:16 p.m., R4 continued yelling Nurse please help me. During an interview on 2/8/26 at 3:18 p.m., Certified Nurse Aide (CNA) L was queried about R4 and when she last received care. CNA L reported I honestly couldn't tell you. During an observation and interview on 2/9/26 at 4:20 p.m. R4 was yelling for help from her room. Upon entering her room, the smell of urine permeated the room. R4 was shivering in her bed. R4 stated I am so cold, I am so full of piss and I am so wet.would you please come and help me? I told that little nurse and she has not come in to help me. R4 had tears [NAME] up in her eyes and coming down her cheeks and stated, I am so tired of not being cared for, they don't take care of me here. I am from this town and I want to get the hell out of this place. I don't want to be here. I don't want to die here like this. Review of the Minimum Data Set (MDS) assessment, dated 1/8/2026, revealed R4 was admitted to the facility on [DATE] and had diagnoses including dementia, sarcopenia (age-related muscle loss), abnormal gait, generalized weakness and chronic respiratory failure. Further review of the assessment, revealed R4 had severe cognitive impairment, frequent urinary incontinence and was occasionally incontinent of bowel. During an interview on 2/9/26 at 4:28 p.m., the Senior Director of Nursing (DON) CC and the Director of Nursing (DON) were notified of R4 yelling for help. During an interview on 2/11/26 at 9:38 a.m., the Nursing Home Administrator (NHA) acknowledged concern regarding resident sitting in urine, feces, and shivering and the need for nursing care for resident. Review of policy titled Abuse, Neglect, and Exploitation date reviewed/revised 1/10/24, read in part .Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure accurate nurse staffing information was posted on a daily basis, resulting in the potential for all 86 residents and their representatives to be misinformed of current facility staffing.Finding include:During initial entry to the facility on 2/8/2026 at 12:20 p.m., the Daily Nurse Staffing Form, was observed posted on the wall at the end of E-Hall, near the nurses' station. The form was dated 2/6/2026 and the resident census was listed as 84. The Nursing Home Administrator (NHA), present at the time of the observation, reported the current census to be 86. During an interview on 2/9/2026 at 12:05 p.m., facility scheduler, Staff VV reported she was responsible for ensure the posting of the Daily Nurse Staffing Form, during her work week, which was Monday through Friday. Staff VV reported she provided pre-filled forms for nursing staff to complete and post on Saturdays and Sundays. Staff VV was asked how the forms could be accurate if filled out ahead of time to which she reported, nursing staff were instructed to make adjustments on the form, if necessary, such as if the census changed and when more or less staff is needed based on resident acuity and care needs. Staff VV presented the Daily Nurse Staffing Form, dated 2/08/2026, the day of survey entry. Review of the form revealed no census number included on the form to reflect the prefilled staffing numbers reported as prefilled by Staff VV. Staff VV confirmed the facility had new admissions since 2/06/2026 and there was a potential the staffing needs in the facility had changed with the arrival of new admissions from 2/06/2026 through 2/08/2026, increasing the census from 84 to 86. Staff VV reported the staffing form for 2/08/2026 did not accurately reflect the needs of the facility for that day and she was unsure why nursing had not adjusted and posted the staffing from on 2/08/2026. During an interview on 2/10/2026 at 4:45 p.m., the Nursing Home Administrator (NHA) confirmed the Daily Nurse Staffing Form(s), should be completed and posted daily to reflect the current census and staffing needs of the facility.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview and record review, the facility failed to provide a qualified dietitian, other clinically qualified nutrition professional, and/or director of food and nutrition services who met the required qualifications in the timeframe allowed. Findings include: On 2/8/2026 at 3:15 PM, Dietary Director C was asked if he was a Certified Dietary Manager or if he had a food service manager certification and stated he is working on his Dietary Manager certificate but is not currently certified. He stated he is also not a Certified Professional Food Manager through a nationally accredited program. He stated he has many years of experience. On 2/9/2026 at 4:00 PM, during interview with the Nursing Home Administrator NHA it was discussed that the dietary manager was not a certified dietary manager nor a Certified Professional Food Manager and that he was unable to produce any certificates showing he was certified in a nationally recognized food manager program. NHA stated that Dietary Director C was supposed to have submitted these after hiring.

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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. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include: During a lunch meal observation on B Hall 2/8/2026 at 1:47 PM, CNA I was moving in and out of resident rooms bringing soiled meal trays back to the food cart for transport to the kitchen to be washed. At 1:51 PM on 2/8/2026, the food cart was observed to have six unserved meal trays remaining inside along with soiled food trays. Some of the soiled trays had been placed above the unserved trays and two soiled trays had been placed on the same shelf next to two unserved trays, touching and blocking service. CNA R looked into the cart and said, I'm not sure who did this. There is not supposed to be dirty trays in with the new trays. During a breakfast meal observation on D Hall 2/9/2026 at 9:43 AM, the food cart on the hall was observed. One tray remained to be served, and eight soiled trays had been returned from resident rooms and placed in the cart with the unserved tray. CNA L and CNA O approached the food cart. CNA L stated they had to wait to serve the last tray because the resident was a 2-person approach. When they opened the food cart CNA L said, Oh they should not have put dirty trays in with her meal. 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: .(b) Arranging each type of FOOD in EQUIPMENT so that cross contamination of one type with another is prevented . On 2/8/2026 at 12:35 PM observed the hood filters above the cooking equipment were soiled with dust and debris. On 2/8/2026 at 1:13 PM stainless steel steam table pans were observed stored on the lower storage shelf below the steam table. The shelf was partially covered with the original protective plastic sheeting, which was noted half peeled off and what remained was soiled with food debris and grime. The pans were observed turned upside down sitting on the soiled surface with food debris on the pans themselves. According to the 2022 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in ¶ (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLEUSE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under ¶ (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. On 2/8/2026 at 1:15 PM the garbage disposal was observed backed up and the bowl of the unit was half full of wastewater. Kitchen dietary aide A stated that it has been broken for a while, and a work order has been placed to repair it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2 On 2/8/2026 at 1:20 PM observed dietary cook B drink from a bottle on the prep line, place the drink bottle back down on the prep table and then take the cleaned parts of the food processor and place them on top of the food processor without washing hands prior to touching the cleaned utensils. According to the 2022 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and:(A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in ¶ 2-403.11(B); (D) Except as specified in ¶ 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands. Upon record review of the Infection Prevention and Control Program, revised and reviewed on 12/27/2023 states: Policy #15 Staff Education: a. Staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. b. Staff shall demonstrate competence in relevant infection control practices. On 2/9/2026 at 8:15 AM a large 1000-piece box of single serve Styrofoam cups, two 1000 count boxes of Hot or Cold Insulated bowls and one 1000 count box of single serve lids were observed sitting on the floor of the dry storage room. According to the 2022 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in ¶ (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLEUSE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to maintain a comprehensive and accurate facility assessment to ensure sufficient staffing levels for all 86 residents of the facility.Findings include:Review of the facility assessment, revised 9/16/25, revealed an average daily census of 72, ranging from a minimum of 64 residents to a maximum of 78 residents.Review of facility census numbers from 10/1/25 - 2/11/26 revealed 90 days the census exceeded the maximum census (78 residents) outlined by the facility assessment. The highest census in this timeframe was 87 residents on 2/6/26.Review of the facility assessment's resident acuity levels revealed the subsequent population percentages requiring maximum assistance or total dependency for the following activities of daily living (ADLs):Self-care (eating, oral hygiene, toileting hygiene, bathing, upper and lower body dressing, donning and doffing footware [sic]): 37% Bed Mobility: 40%Transfers: 54% Walking: 51%Wheelchair/Scooter: 48% Review of the facility assessment's, Staffing Plan subsection revealed the following: .The scheduler uses a staffing ladder based on the facility budget to determine baseline staffing requirements.Day Shift 5-7 C.N.A.'s [certified nursing assistants] and 2-3 nursesAfternoon shift 5-7 C.N.A.'s and 2-3 nursesMidnight shift 3-5 C.N.A.'s and 2-3 nurses.Develop and maintain a plan to maximize recruitment and retention of direct care staff.Staffing/Recruitment meetings are held daily to maximize our recruitment and retention efforts.Review of the facility assessment's Other section read:Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing. See Appendix 3 for more details.Since we are a member of a large corporation, we have the opportunity to utilize staff from other facilities when needed.Further review of the facility's assessment's Appendix 3 read: Contingency Plans: Describe your contingency planning for events that do not require activation of the facility's emergency plan but do have the protentional to affect resident care such as available of direct care nursing staffing. For example, how are call-offs managed? What if you discover there will be 5 admissions arriving after 5 PM? What if a direct care staff member must leave mid-shift due to illness or a family emergency?This portion of the facility assessment was left blank apart from various staff signatures.On 2/11/26 at 9:47 AM, an interview was conducted with the Nursing Home Administrator (NHA) regarding low staffing level concerns in relation to inaccurate data, incomplete portions, and an inadequate staffing plan in the facility assessment. The NHA responded, We don't have a staffing problem, we have a call-in problem [staff reporting they are unable to work their shift]. Therefore, no retention or recruiting efforts/meeting nor utilization of staff from other facilities occurred. The NHA made no comment as to why the facility assessment did not contain a staffing contingency plan but stated phone calls are made to try to get other staff to come in to work in the event of a call-in. When asked if 3 CNAs are considered sufficient staff to safely and adequately cover a census of 79 or greater with the aforementioned mobility level acuity data, the NHA did not respond.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to develop and maintain a Quality Assistance and Process Improvement (QAPI) program which identified and prioritized quality deficiencies, systematically analyzed the underlying causes of systemic quality deficiencies, and implemented effective corrective action or performance improvement activities to remedy those deficiencies. This deficient practice has the potential to affect the safety and quality of life of all 86 residents at the facility.Findings include:On 2/11/26 at 9:47 AM, an interview was conducted with the Nursing Home Administrator (NHA) regarding concerns of low staffing levels translating to quality-of-care concerns and systemic issues in several areas including assistance with activities of daily living (ADLs), incontinence care, prompt and palatable meal service, positioning needs, and honoring resident preferences which were identified during the recertification process. Review of the facility's performance improvement projects with the NHA failed to reveal staffing levels concerns nor any other systemic issues had been appropriately identified and carried out through the QAPI process. When asked if low staffing levels had been identified as a concern, the NHA stated, Not at this time. We are fully staffed right now. We have a couple open nurse positions we need to fill. CNAs [certified nursing assistants] are fully staffed. The NHA was asked if she was aware the facility triggered for excessively low weekend staffing on the third quarter PBJ report to which she replied, Through the survey process, I am. When asked if excessively low weekend staffing was considered a staffing problem, the NHA replied, We don't have a staffing problem, we have a call-in problem [staff reporting they are unable to work their shift]. The NHA stated they have not discussed a contingency staffing plan in QAPI but have instead been enforcing employee attendance expectations. The NHA stated, We need to focus a little bit more on our process after call-ins. We are following up with our attendance policy and our write-up [disciplinary] policy. The NHA did not respond when asked if this solution was effective.Review of the Payroll Based Journal (PBJ) Data Report for Quarter 4, 2025 (July 1 - September 30) revealed the facility triggered for excessively low weekend in the same timeframe.On 2/11/26 at 10:10 AM, the Regional Director of Operations (RDO) LL stated, Our QAPI program needs work.Review of the facility policy titled, QAPI Plan, reviewed 10/24/22, read, in part: It is the policy of this facility to systematically collect data as part of the QAPI program to ensure the care services it delivers meet acceptable standards of quality in accordance with recognized standards of practice. The goal is to create a process that ensures care and services delivered meet accepted standards of quality. The QAPI program will be ongoing, comprehensive, and will address the full range of care and services provided by the facility. At a minimum, the QAPI program will: i. address all systems of care and management practices. ii. Include clinical care, quality of life, and resident choice. All identified problems will be addressed and prioritized. Considerations include, but are not limited to: i. high-risk, high-volume, or problem prone areas. ii. Incidence, prevalence, and severity of problems in those areas. iii. Measures affecting resident health, safety, autonomy, choice, and quality of choice. Once the root cause of a problem is identified, the QAA [Quality Assessment and Assurance] committee oversees the development of the of an appropriate corrective action. An appropriate corrective action is one that addresses the underlying cause of the issue comprehensively, at the systems level.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to incorporate high-risk, high-volume, and high-priority quality concerns from feedback obtained from direct care staff, residents, and resident representatives into an effective Quality Assistance and Process Improvement (QAPI) program. This deficient practice resulted in ongoing quality-of-care concerns and systemic issues in several areas including assistance with activities of daily living (ADLs), incontinence care, prompt and palatable meal service, positioning needs, and honoring resident preferences which had the potential to affect all 86 residents in the facility. Findings include:Review of Quality Assistance Forms submitted to the facility Nursing Home Administrator (NHA) revealed 15 grievances from staff, residents, and/or resident representatives related to low staffing concerns since June 2025.Review of Resident Council Meeting Minutes since March 2025 revealed repeated staffing concerns, including excessively late mealtimes, for the previous 9 out of 11 months. On 2/9/26 at 2:00 PM, a confidential group interview was conducted where eight out of nine residents stated the facility still had ongoing low-staffing concerns directly translating to poor resident outcomes.Throughout the recertification process (2/8/26-2/11/26), three staff members across three non-nursing departments (activities, dietary, and housekeeping) relayed their concerns regarding low staffing:On 2/11/26 at 8:05 AM, an interview was conducted with Activities Director (AD) KK regarding the repeated staffing/call light and untimely meal services issues that came up in the monthly Resident Council meetings. AD KK stated she brought these concerns up to management with a Quality Assistance Form after every meeting. When asked the response she receives from management after submission of the form, AD KK responded, They [management] tell me we meet staffing guidelines.On 2/11/26 at 8:15 AM, an interview was conducted with Dietary Manager (DM/Staff) C regarding repeated issues with timely meal services. Staff C stated the food is prepared and ready to be served on trays at the established mealtimes, but the facility is lacking the staff to deliver them in a timely manner. Staff C stated when this issue is presented to management it, goes nowhere.On 2/11/26 at 8:05 AM, an interview was conducted with Housekeeper/Staff NN regarding their opinion of staffing levels. Staff NN replied, I think they're [certified nursing assistants] short staffed. They get to call lights when they can. Review of a complaint submitted to the State Agency (SA) on 12/29/25 read, in part: .The safety of the staff and residents are progressively becoming more dangerous. From morning to nights there is never enough staff from the halls to the dining area. A lot of the residents sit in their own stool and urine for hours on end throughout the day due to inadequate care from employees and staffing shortages all day. For many months I have worked 1 CNA to 30 residents a hall due to inadequate staffing measures.On 2/11/26 at 9:47 AM, an interview was conducted with the Nursing Home Administrator (NHA) regarding the QAPI process. When specifically asked if low staffing levels had been an identified concern in QAPI as the result of extensive feedback from staff, residents, and resident representatives, the NHA stated, Not at this time. We are fully staffed right now. We have a couple open nurse positions we need to fill. CNAs [certified nursing assistants] are fully staffed. When asked how she interpreted the large quantity of grievances, resident council minutes, and staff interviews related to low staffing concerns, the NHA replied, The way we're addressing staffing is through our write-up [disciplinary] process . Following our attendance policy and doing write-ups. We are just getting started on this process. The NHA did not respond when asked why this was not implemented in March 2025, when staffing concerns were first voiced. Review of the facility policy titled, QAPI Plan, reviewed 10/24/22, read, in part: .Data will be collected from all departments, residents, and family members. sources of data include, but are not limited to: . grievance logs. staffing trends. Quality measures (QM report)/5 star reports.suggestions from staff, residents, and families. at staff meetings, or shift-to shift huddles. Resident Council Minutes. Performance indicators will be established based on data, and will be monitored/evaluated in the [Quality (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assessment and Assurance] Committee meetings. The facility draws data from multiple sources, including input from all staff, resident, families, and others as appropriate. All identified problems will be addressed and prioritized.Review of the Facility Assessment, reviewed 9/16/25, read, in part: .The QAPI committee, along with input from all staff, identifies areas for improvement and devise action plans to correct potential areas that are deficient or to improve an area identified by staff for improvement. How do we determine if we have sufficient staffing? Consider the following: Gather input from residents, family members, and/or resident representatives, CNAs, licensed nurses providing direct cares, and the long-term care local ombudsman about how well the current staffing plan has been working and any concerns, and make sure to consider this information when developing the staffing plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2702621.Based on observation, interview, and record review, the facility failed to:Implement Enhanced Barrier Precautions (EBP) in a timely manner for six Residents (#33, #93, #90, #92, #94, & #91).Properly don (put on) personal protective equipment (PPE) prior to entering EBP rooms.Update infection control policies on an annual basis.Maintain sanitary medication and treatment carts.Ensure appropriate hand hygiene during feeding assistance.Ensure separation of unserved food trays and soiled meal trays within transport carts.These deficient practices resulted in the potential for the transmission of pathogens between residents and the spread of infectious organisms to all 86 residents in the facility. Findings include:On 2/8/26 at 12:33 PM, an observation was made of the B Hall medication cart and had two drinks sitting on top of the cart. One drink was coffee and the other was a can of name brand energy drink. On 2/8/26 at 12:40 PM, an interview was conducted with Registered Nurse (RN) X who was asked if open drinks on top of a medication cart were very sanitary and replied, No, the drinks should not be there. Resident #91 (R91) the facesheet for R91 had an original admission to the facility on 2/6/26 with diagnoses including fracture of the right tibia/fibula (fracture of both lower leg bones), anxiety, and depression. According to R91's Minimum Data Set (MDS) dated [DATE], a Brief Interview for Mental Status (BIMS) score of 15/15 indicated R91 was cognitively intact. On 2/8/26 at 12:35 PM, an observation was made of R91's room which lacked any signage for enhanced barrier precautions (EBP) or a personal protective equipment (PPE) cart outside of the room. On 2/8/26 1:30 PM, an observation was made of R91 receiving physical therapy from Occupational Therapist (OT) RR who was not wearing proper PPE and lacked wearing a gown. Review of R91's physician order, dated 2/9/26, for enhanced barrier precautions was not placed until three days after her admission to the facility at 8:40 AM. Resident #93 (R93) The facesheet for R93 had an original admission to the facility on 1/29/26 with diagnoses including fracture of the left tibia/fibula (fracture of both the lower leg bones), diabetes mellitus, and chronic kidney disease requiring dialysis (a treatment where blood is filtered of waste and excess fluid by a machine). R93 had a dialysis port in her chest. According to R93's MDS dated [DATE], a BIMS score of 15/15 indicated R93 was cognitively intact. R93's MDS assessment indicated she was dependent on staff for bathing, requiring the assistance of two staff personnel, and for toileting R93 was a one-person assist. On 2/8/26 at 12:37 PM, an observation was made of R93's room which lacked any signage for EBP or a PPE cart outside of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R93's physician order, dated 2/9/26, for EBP was not placed until three days after her admission to the facility at 8:42 AM. On 2/10/26 at 3:10 PM, an observation was made of Licensed Practical Nurse (LPN) U removing R93's right leg brace without wearing a gown. During an interview on 2/10/26 at 3:18 PM, an interview was conducted with LPN U who was asked if he should have been wearing a gown during the removal of R93's right leg brace and replied, Yeah, I should have I did not realize she was EBP resident. The Director of Nursing (DON) confirmed on 2/10/26 at 4:10 PM that open personal drinks should not be left on top of medication carts and staff are to be wearing PPE during direct care contact with residents under EBP. Resident #33 (R33) Review of R33's Electronic Medical Record (EMR) revealed initial admission to the facility on 1/19/26. Review of Section M: Skin Conditions on R33's Minimum Data Set (MDS) Assessment, submitted 2/4/26, revealed one stage two pressure ulcer that was present upon admission. Review of R33's EMR revealed the following physician's order, initiated 2/2/26 (14 days after admission to the facility): Use enhanced barriers while performing high contact activity with the resident. Resident #93 (R93) Review of R93's EMR revealed initial admission to the facility on 1/28/26 with diagnoses including dependence on renal dialysis with presence of a right central venous catheter. Review of R93's EMR revealed the following physician's order, initiated 2/9/26 (12 days after admission to the facility): Use enhanced barriers while performing high contact activity with the resident. Resident #90 (R90) Review of R90's EMR revealed initial admission to the facility on 1/29/26 with diagnoses including fracture of the 3rd, 4th, 6th and 7th cervical (neck) vertebrae. Review of R90's Plan of Care reviewed a focus, initiated 1/29/26, that read, in part: Resident has impaired skin integrity as evidenced by: surgical incision to neck related to.recent surgery. Review of R90's EMR revealed the following physician's order, initiated 2/9/26 (11 days after admission to the facility): Use enhanced barriers while performing high contact activity with the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #92 (R92) Review of R92's EMR revealed initial admission to the facility on 1/30/26 with diagnoses including acute kidney failure and benign prostatic hyperplasia. Review of R92's EMR revealed a progress note dated 2/3/26 at 18:59 [6:59 PM] that read, in part: Returned from ER [emergency room] with indwelling cath [catheter] for urinary retention. Review of R92's EMR revealed the following physician's order, initiated 2/9/26 (3 days after re-admission to the facility): Use enhanced barriers while performing high contact activity with the resident. Resident #94 (R94) Review of R94's EMR revealed initial admission to the facility on 2/6/26 with diagnoses including fracture of the right femur requiring surgical intervention. Review of R94's EMR revealed the following physician's order, initiated 2/9/26 (3 days after admission to the facility): Use enhanced barriers while performing high contact activity with the resident. Resident #91 (R91) Review of R91's EMR revealed initial admission to the facility on 2/6/26 with diagnoses including fracture of the right tibia. Review of R91's Plan of Care reviewed a focus, initiated 2/7/26, that read, in part: Resident has imparted skin integrity as evidenced by: surgical incision to right leg related to fracture to the right tibial [sic]. Review of R91's EMR revealed the following physician's order, initiated 2/9/26 (3 days after admission to the facility): Use enhanced barriers while performing high contact activity with the resident. Review of the following facility policies revealed the respective reviewed and/or revised dates: Infection Prevention and Control Program Policy and Procedures - Date Reviewed/Revised: 12/27/23. Antibiotic Stewardship Program Policy - Date Reviewed/Revised: 12/13/23. Influenza Vaccine Policy - Reviewed/Revised: 10/26/23. Pneumococcal Vaccine Policy - Reviewed/Revised: 10/30/23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/10/26 at 12:59 PM, an interview was conducted with Infection Preventionist (IP) T regarding infection control concerns within the facility. IP T acknowledged the concern regarding delayed implementation of EBP, stating this often gets missed if she is out of the facility because there is not a designated back-up person to oversee the process. IP T stated since the arrival of the State Agency (SA) [on 2/8/26], she has begun educating staff, especially unit managers, on the medical indications for EBP and how to appropriately initiate those orders in the EMR upon admission of the resident. IP T confirmed the provided Infection Prevention and Control Program Policies and Procedures, including the Antibiotic Stewardship program and the Influenza, Pneumococcal, and COVID-19 Immunization Policy & Procedures were the most up-to-date versions available. Review of the facility policy titled, Enhanced Barrier Precautions (EBP), revised 3/26/24, read, in part: .Initiation of Enhanced Barrier Precautions - . even if the resident is not known to be infected or colonized with a MDRO [multidrug-resistant organisms], an order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g. chronic wounds such as pressure injuries.unhealed surgical wounds.). Indwelling medical devices (e.g. central lines, urinary catheters.). Review of the facility policy titled, Infection Prevention and Control Program, revised 12/27/23, read, in part: .Annual Review: The facility shall conduct an annual review of the infection prevention and control program, including associated programs and policies and procedures based upon the facility assessment which includes any facility and community risk. Resident # 90 (R90) and Resident #98 (R98) On 2/8/2026 at 3:00 p.m., CNA L was observed pushing two wheeled carts of PPE down D-Hall. CNA L deposited one cart inside R90's room and the other into R98's room. When asked why the carts were being placed in the rooms, CNA L stated, I don't know, I'm just doing what I was asked. During the same period of observation, Unit Manager, LPN S was observed adhering signs for EBP on the doorways of R90 and R98's rooms. Review of R90's EMR revealed an admission date of 1/29/2026. Review of R90's active physician orders revealed, Cleanse incision on neck with wound cleanser. Cover with island dressing. Change daily in the afternoon for surgical wound. Start date: 2/4/2026. Review of R90's February 2026 Medication and Treatment Administration Record(s) (MAR/TAR) revealed documentation of consistent daily dressing changes per the order. Further review revealed an order for the use of Enhanced Barrier Precautions (EBP) while performing all high-contact activity with the resident . Surgical wound. Start date: 2/9/2026. Review of R90's care plan revealed, Resident has impaired skin integrity as evidenced by: surgical incision to neck . Date initiated: 1/29/2026. Review of R98's EMR revealed an admission date of 2/5/2026. Review of R98's active physician orders revealed, Border gauze to left abdomen change daily and prn [as needed] one time a day for abdominal incision. Start date: 2/6/2026. Review of R98's February 2026 MAR and TAR revealed documentation of consistent daily dressing changes per the order. Further review revealed an order for the use of EBP while performing all high-contact activity with the resident . Start date: 2/6/2026. Review of R98's care plan revealed, Resident requires Enhanced Barrier Precautions related to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	surgical wound. Date initiated: 2/6/2026. Facility An observation on 2/8/2026 at 1:50 p.m. revealed a treatment cart positioned in the D Hall corridor, Further observation revealed dark rings on the surface of the top of the cart resembling coffee rings as if a drink had been sitting on the cart. The surface of the cart appeared visibly soiled and a large amount of debris and dust was observed under the two boxes of gloves positioned the glove rack. An observation on 2/9/2026 at 9:48 a.m. revealed a treatment cart positioned in the corridor of B Hall. Further observation revealed a supply of disposable cups and straws sitting atop the cart. Food crumbs were visible on the surface of the cart and the empty glove rack was observed to have a large amount of debris including pieces of straw wrapper, hair, dust and larger black unidentifiable particles. Registered Nurse (RN) observe M, who was present at the time of the observation, reported she believe the CNA staff used the cart as an extra surface when passing meals and snacks. RN M confirmed the cart housed wound care supplies and the surface is used when pulling supplies from the cart in preparation for wound care. During a lunch meal observation on 2/10/2026 at 12:35 PM, Certified Nurse Aide (CNA) J was feeding R83, a resident needing partial/moderate assistance with feeding (according to her Minimum Data Set [MDS] assessment dated [DATE]). After serving several spoonfuls of food to R83, CNA J set the utensil down, adjusted the plate and moved to assist R50. Following assistance feeding R50, CNA J then moved to another chair at the same table and assisted R44 with his tray. CNA J moved from chair to chair back and forth assisting the three residents using different utensils and cups, and adjusting the plates, trays, and clothing protectors. CNA J did not perform hand hygiene at any time during the lunch observation. When CNA J was asked if she should be performing hand hygiene between assisting residents, she replied she was not 100% sure. CNA J said, I will find out for you. She explained there had been another person assisting residents with the meal at her table, but the Nursing Home Administrator (NHA) had needed her, CNA J was left to feed the residents at her table alone. The facility policy titled, Hand Hygiene was dated as reviewed/revised on 12/13/2023. This policy read in part, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. During a lunch meal observation on B Hall 2/08/2026 at 1:47 PM, CNA I was moving in and out of resident rooms bringing soiled meal trays back to the food cart for transport to the kitchen to be washed. At 1:51 PM on 2/8/2026, the food cart was observed to have six unserved meal trays remaining inside along with soiled food trays. Some of the soiled trays had been placed above the unserved trays and two soiled trays had been placed on the same shelf next to two unserved trays, touching and blocking service. CNA R looked into the cart and said, I'm not sure who did this. There is not supposed to be dirty trays in with the new trays. During a breakfast meal observation on D Hall 2/09/2026 at 9:43 AM, the food cart on the hall was observed. One tray remained to be served, and eight soiled trays had been returned from resident rooms and placed in the cart with the unserved tray. CNA L and CNA O approached the food cart. CNA (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	L stated they had to wait to serve the last tray because the resident was a 2-person approach. When they opened the food cart CNA L said, Oh they should not have put dirty trays in with her meal. 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: .(b) Arranging each type of FOOD in EQUIPMENT so that cross contamination of one type with another is prevented .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. This citation pertains to Intake 2702621. Based on observation and interview, the facility failed to maintain general cleanliness and repair of the facility, resulting in an increased potential for contamination and a possible decrease in satisfaction of living to all residents. Findings Include:On 02/08/2026 at 1:34 PM observed a pink Caution Wet Floor sign on the floor sitting next to a waste container with a couple of inches of water in it in in the front entrance foyer across from the front door. The ceiling around the sky light above this area was observed water damaged. On 02/09/2026 at 8:45 AM during interview with Maintenance Director D stated that he has tried a few times to repair the roof but was told that it could void the roof warranty and not to attempt to repair any further.On 02/08/2026 at 2:55 PM observed the floor in the bathroom shared between rooms D 14 and D 16 was soiled and the paint on the door and door frame was observed chipped and worn off along the bottom of the door and casing.On 02/08/2026 at 2:57 PM in room D 11 observed damaged walls and paint missing in several locations exposing the bare plaster wall below. On 02/08/2026 at 3:00 PM wall paint was observed missing in room D 9. On 02/08/2026 at 3:05 PM the cove base molding was noted peeled away from the wall in D 5.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assist, set up, or place meals within reach for four Residents (#4, #47, #69, and #83) of four residents reviewed for reasonable accommodation of needs.Resident #4 (R4) Review of R4's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 7/25/23 with diagnoses including malnutrition, depression and anxiety disorder. R4 scored 3 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. During an observation on 2/9/26 at 4:20 p.m., R3's lunch was sitting on her bedside table away from her bed and out of reach of the resident. The sandwich was covered with plastic wrap. During an observation on 2/10/26 at 8:32 a.m., R4 laid in bed with her meal try on the bedside table with the food and beverage covers over her food and beverage items. The food was out of the reach of the resident. Review of R4's menu card dated 2/10/26 read in part .Regular diet, thin liquids Alert: Independent, offer set up assistance (for meals). During an observation on 2/10/26 at 10:14 a.m., Hospitality aide G walked into R4's room and picked up the breakfast tray. R4 had not eaten any of the food from the tray as it was out of her reach. Hospitality aide G walked out of R4's room and did not offer any food or beverage to R4. Resident #47 (R47) Review of R47's MDS assessment, dated 1/16/26 revealed admission to the facility on 5/16/25 with diagnoses including diabetes mellitus and hip fracture. R47 scored 13 of 15 on the BIMS assessment reflective of intact cognition. During an observation on 2/9/26 at 9:45 a.m., R47 was lying in his bed with a tray of food that had food covers over the food and out of the resident's reach. Review of the menu card revealed R47 had been given another resident's meal tray. Review of facility policy titled Tray Identification last reviewed/revised 7/1/25, read in part .To assist in setting up and serving the correct food trays/diets to resident .the food services manager or designee will check trays for correct diets before the food cares are transported to their designated areas. Nursing staff shall check each food tray for the correct diet before serving the residents . During an observation on 2/9/26 at 9:56 a.m., Licensed Practical Nurse (LPN) H walked into R47;'s room and removed the meal tray from R47's bedside. LPN H did not offer any food or beverage to R47. Review of R47's menu card dated 2/9/26 read in part, .Alert: Independent offer set up assistance (for meals). Review of policy titled Resident Meal Service date reviewed/revised 7/1/25, read in part . Nursing personnel will ensure that residents are served the correct food tray.prior to serving the food tray, the Nurse Aide/feeding assistant must check the tray card to ensure that correct food tray is being served to the resident. (continued on next page)

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	235292	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste. Marie	1011 Meridian Road Sault Ste. Marie, MI 49783

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #69 (R69) Review of the MDS assessment, dated 1/24/2026, revealed R69 was admitted to the facility on [DATE] with diagnoses including demyelinating disease of the central nervous system, osteoporosis, arthritis, generalized weakness and frequent falls. Further review of the assessment revealed R13 required set-up assistance only with eating, substantial/maximal assistance with sitting to standing and partial/moderate assistance with chair/bed-to-chair transfers. R69 scored 13 out of 15 on the BIMS, indicating there is mild cognitive impairment. On 2/9/2026 at 10:10 AM R69 was observed lying in bed, awake. The left side of the R69's bed was against the wall, and a fall mat was positioned on the floor on the right side of the bed. An over bed table was positioned approximately two feet from the resident in bed and on the opposite side of the fall mat. Atop the over bed table was a meal tray containing an unopened container of oatmeal, an unopened lidded glass of apple juice and an unopened lidded glass of milk. At the time of the observation R69 reported she must have been asleep when the tray was dropped off in her room. R69 was asked if she was able to retrieve her meal from across the room to which she answered, I think I can manage. R69 was observed attempting to rise by swinging her legs over the side of the bed but was unable to rise to a seated position. During the observation, Certified Nurse Aide (CNA) L entered the room and was queried as to the location of R69's breakfast tray and if the Resident had the ability to retrieve the tray herself. CNA L reported R69 had declined in recent weeks and required assistance to set up meals. CNA L was unsure when the meal was placed in R69's room and confirmed the oatmeal was coagulated and cold at the time of the observation. On 2/11/2026 at 8:25 AM an observation revealed Resident #69's morning meal tray atop an overbed table positioned against the wall between the resident's sink and bathroom door on the opposite side of the room from the Resident's bed. R69 was observed lying in bed with her legs over the side of the bed and feet resting on the fall matt that was positioned on the floor on the right side of the bed. CNA PP was approached in the hallway as she was passing meal trays to other resident rooms. CNA PP entered R69's room with this surveyor and reported she placed the tray in the Resident's room, but there was no one else in the hall at the time to assist in passing meal trays, so she left the tray without setting it up so she could pass the remaining trays. CNA PP stated she intended on returning to assist the resident with set up. When asked if the resident would attempt to retrieve the tray herself upon waking, CNA PP stated Oh, she never tries that. Review of R69's care plan revealed the following: Resident is at risk for altered nutritional status . Provide assistance with meals, as needed. Dated initiated: 6/06/2025 . Resident is at risk for falls/injury . Encourage resident to keep needed items within reach. Dated initiated: 12/30/2024. Resident #83 (R83) According to the medical record, R83 was admitted on [DATE] with medical diagnoses including quadriplegia (paralysis affecting all four limbs and the torso), anoxic brain damage (damage from a shortage of oxygen to the brain), need for assistance with personal care, major depressive disorder and post-traumatic stress disorder (PTSD). R83's MDS assessment dated [DATE] contained a BIMS score of 14 of 15, indicating R83 was cognitively intact. R83's functional status assessment revealed total dependence on staff to roll right or left, total dependence of staff to lie down from sitting, and total dependence on staff to sit from lying down. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/10/2026 at 11:08 AM, R83 was lying in bed with her breakfast tray on the bedside table away from the bed and pushed up against the wall of the room. The breakfast meal tray appeared to be untouched. When R83 was asked if she saw her breakfast which was positioned approximately 2-3 feet from the bed, she replied, I did not even see it. When asked if she was hungry, R83 replied with an emphatic yes and indicated she would like to eat. When asked if she needed help, R83 said she did as she stated she could not reach the tray. The tray card included with the meal read in part: Needs assistance with meals. The medical record included a care plan for activities of daily living with interventions including: EATING: 1 person assist, independent with finger foods & set up assistance Date Initiated: 08/18/2023. Another care plan had a focus of Resident is at risk for altered nutritional status RT (regards to) functional quadriplegia., finger food texture order, required assistance with meals if not finger foods texture Date Initiated: 12/19/2023 Revision on: 06/16/2025 with an intervention included for this focus of, Provide assistance with meals as needed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. This citation pertains to intake 2702621. Based on observation, interview, and record review, the facility failed to provide a homelike dining environment for five of nine residents interviewed in a confidential group meeting. Findings include: During lunch observations on 2/8/2026 at 1:17 PM, the meal was delivered in food carts and served on trays. During observation on the A Hall and B Hall each tray included only disposable plastic utensils. Certified Nurse Aide (CNA) R serving the meal stated disposable plastic utensils often came on the trays. CNA R said sometimes meal trays sat near the kitchen door in the dining room and did not get washed in time for the next meal. During breakfast observations on 2/9/2026 at 8:31 AM, the meal was delivered to the halls in food carts and served on trays. During this observation on the A Hall, each tray included regular forks and spoons and plastic disposable knives. On 2/11/2026 at 10:27 AM, the Food Service Manager/Staff C stated, It goes down the hall, and it does not come back. Staff C said the trays did not come back in time to be washed for the next meal and he felt residents were keeping the silverware. Staff C knew the disposable plastic utensils were being used and he had not ordered any more silver utensils. On 2/9/26 at 2:00 PM, a confidential group interview was conducted where five residents voiced their frustration with the plastic cutlery served at mealtimes. One Confidential Resident (CR) stated, It [a plastic knife] won't even cut the meat. Review of a complaint submitted to the State Agency (SA) on 12/29/25 read, in part: .meals are never adequately served due to limited utensils. Review of the facility policy titled, Residents' Rights and Quality of Life, reviewed 1/1/22, read, in part:It is the policy that all residents have the right to a dignified existence.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to secure medications, maintain the security for one medication cart of three medication carts and three of five treatment carts reviewed for medication storage. Findings include:On 2/8/26 at 12:37 PM, an observation was made of Resident #64 (R64) lying in his bed asleep with a full cup of medications sitting on his bedside table.On 2/8/26 at 12:38 PM, an observation was made of Resident #91 (R91) lying in her bed with a full cup of medications sitting on his bedside table. R91's medications were later identified as being morning medications. R91 also had a rescue inhaler on her bedside table identified as albuterol.An observation was made on 2/9/26 at 11:45 AM, of Resident #93 (R93) who had a topical ointment on her bedside table. R93 states it is her ointment mupirocin. During an observation on 2/8/26 at 12:53 PM, A Hall treatment cart was unlocked with a tube of diclofenac sodium topical gel 1% and an opened can of soda pop on top of treatment cart.During an interview on 2/8/26 at 1:26 PM, Registered Nurse (RN) Q reported she started working at 6:00 AM, and she had not completed any of the treatments for the residents on A Hall but did acknowledge the treatment carts should be locked when licensed staff are not using them.Record review and observation on 2/9/26 at 1:50 PM, revealed R93 had medication at the bedside table ointment mupirocin 2% and there was no order or an assessment for medication self-administration.Review of the medication administration record (MAR), dated 2/8/26, showed R91 had received medications as follows by Registered Nurse (RN) DD dispensed at 10:55 AM:amlodipine 5 milligrams (mg)aspirin 81 mgdesvenlafaxine extended release (ER) 100 mg atorvastatin 20 mgfludrocortisone 0.1 mgfolic acid 400 micrograms (mcg)multivitaminomeprazole 20 mgpotassium chloride 10 milliequivalents (mEq)valsartan 320 mgvitamin D3 125 mcgcarvedilol 25 mgcyclobenzaprine HCL 5 mgapixaban 2.5 mg Review of the medication administration record (MAR), dated 2/8/26, revealed R64 had received medications as follows by RN Q dispensed at 8:06 AM:aspirin 81 mglosartan potassium 100 mgduloxetine HCL 30 mgdapagliflozin propanediol 10 mgtamsulosin HCL 0.4 mgpsyllium two capsules metformin HCL ER 500 mgmultivitaminfinasteride 5 mglactobacillus two capsulesspironolactone 25 mgomeprazole 20 mgGabapentin 100 mgA record review was completed for R64, R91, and R93 and no assessment for medication self-administration, care plan to self-administer medication, or interdisciplinary notes indicating the identified residents ability to self-administer medications could be located.On 2/9/26 at 4:23 AM, an unlocked medication cart was observed located near the nurses' station with no staff present at the nurses' station or near the medication cart.During an observation on 2/9/26 between 4:23 AM, and 4:29 AM, treatment carts were unlocked on A Hall, E Hall, and D Hall.During an observation and interview on 4/9/26 at 4:38 AM, Licensed Practical Nurse (LPN) SS was queried regarding lancets that were left on top of the medication cart with no staff present. LPN SS reported we are not supposed to leave lancets on the medication cart unattended.On 2/10/26 at 4:05 PM, an observation was made of the B Hall medication cart which was unlocked and unsecured. RN N was away from her medication cart and sitting at the nurses' station.On 2/10/26 at 4:15 PM, an interview was conducted with RN N who was asked if she was aware her medication cart was unlocked and unattended and replied, No, I was just signing out a resident to go smoke.Review of policy titled, Medication Storage, dated 1/30/2024, read in part Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy explanation and compliance guidelines: 1. General guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.c. During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.Review of policy (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	titled, Medication - Resident Self-Administration, dated 1/30/2024, read in part Policy: It is the policy of this facility to support each residents' right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determine which medications may be self-administered safely.Policy explanation and compliance guidelines: 1. Each resident is offered the opportunity to self-administer medications during the routine assessment .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2702621Based on observation, interview, and record review, the facility failed to ensure palatable meals were served at preferred and appetizing temperatures for six of nine residents interviewed in a confidential group meeting, and for one Resident (#93) of one resident who voiced concerns about food temperatures. Findings include:On 2/9/26 at 2:00 PM, a confidential group interview was conducted where six residents stated the food delivered at mealtimes is often cold. One Confidential Resident (CR) stated, Sometimes it's cold, other times it's lukewarm. Another CR indicated food trays either sit in the serving window or in food delivery carts for extended periods of time which contributes to the cold food temperatures. One CR revealed they had bought hairnets online in attempt to assist delivering meal trays due to ongoing staffing problems and were upset when the facility would not allow it. The CR indicated they frequently noticed meal trays stacking up in the serving window because there weren't enough staff to deliver them in a timely manner. The CR stated, I feel bad for the other residents, I just want to help deliver trays. Review of Resident Council Meeting Minutes since March 2025 read, in part: 5/15/25: .New Business – Concerns/Complaints/Grievances: Residents stating food (in room) is cold when served. Coffee is sometimes lukewarm/cold in dining room. 6/19/25: .List of old business (unresolved): food still cold down halls. Lukewarm in dining room. 11/20/25: .New Business – Concerns/Complaints/Grievances: staff are pre-pouring coffee making it so residents get lukewarm/cold coffee. 12/17/25: .New Business – Concerns/Complaints/Grievances: Meals being served lukewarm/cold in the dining room/room trays. Residents would like hot food. 1/15/26: .List of old business (unresolved): .Food/coffee temp[erature] – 1/2 state improved, 1/2 not [improved]. Review of the facility policy titled, Resident Meal Service, reviewed 7/1/25, read, in part: Each resident shall receive the correct diet, with preferences accommodated as feasible and shall receive prompt meal service. Resident #93 (R93) The facesheet for R93 had an original admission to the facility on 1/29/26 with diagnoses including fracture of the left tibia/fibula (both of the lower leg bones were broken). According to R93's MDS dated [DATE], indicated a BIMS score of 15/15 indicating R93 was cognitively intact. R93's MDS assessment indicated she was dependent on staff for bathing, requiring the assistance of two staff personnel, and for toileting R93 was a one-person assist. During an interview on 2/9/26 at 12:10 PM, R93 voiced both of her meals, breakfast and lunch were cold. It happens a lot, because they need to check my blood sugar and they are always late. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/8/26 at 1:59 PM, the residents on A Hall received their lunch meal. The temperatures of the food on the last tray on this food cart were measured. The temperatures were as follows: milk 59 degrees, juice 59 degrees, chicken breast 106 degrees, and sliced cooked carrots 107 degrees. The 2022 FDA Food Code reads as follows, Section 501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 degrees C (135 degrees F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3- 403.11(E) may be held at a temperature of 54 degrees C (130 degrees F) or above; or (2) At 5 degrees C (41 degrees F) or less.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2702621.Based on observation, interview, and record review the facility failed to honor resident food preferences or failed to offer substitutes or alternative menu items for 19 of 24 residents (#4, #6, #12, #13, #22, #23, #24, #30, #31, #37, #R41, #47, #48, #77, & #82) and four Residents in a confidential group meeting) reviewed for nutritional services.Findings include:During the lunch meal observation on 2/8/2026 at approximately 1:15 PM, the meal tray cards on each tray specified what each resident preferred or had been ordered by the Physician. Resident #30 (R30) R30 had a meal tray card which indicated, Standing Orders: 8 fl oz (fluid ounces) Assorted Fruit Juices. R30 received 4 oz orange juice. Resident #22 (R22) R22 had a meal tray card which indicated Standing Orders: 4 fl oz Assorted Fruit Juices (lemonade, cran[berry], or apple). R22 received 4 oz orange juice. Resident #48 (R48) R48 had a meal tray card which indicated, Standing Orders: 8 fl oz Assorted Fruit Juices (fill cup). R48 received 4 oz juice. Resident #12 (R12) R12 had a meal tray card which indicated, Standing Orders: 8 fl oz Apple Juice (2 x small). R12 received one 4 oz apple juice not the two as specified. R12's meal tray card also indicated a dislike for, Vegetables (ONLY LIKES corn, green beans, regular potatoes). Sliced cooked carrots were on the menu and R12 did not receive an alternative to carrots and had no vegetables on his plate. Resident #6 (R6) R6 had a meal tray card which indicated, Notes: Can have deli meat/lunch meat. Alternative meal: Ham or turkey sandwich. R6 received a peanut butter and jelly sandwich. Resident #47 (R47) R47 had a meal tray card which indicated, Standing Orders: Would like 2 bowls of soup unless Deli Slip is filled out. R47 did not have a selective menu filled out and did not get any soup on the tray. Resident #82 (R82) No condiments (salt, pepper or sugar) were noted on the meal trays to flavor the food. R82 had a meal tray card which indicated, Standing Orders: . 2 cream, 1 sugar sub (substitute). No cream, sugar, salt or pepper were on the meal tray for R82. The Certified Nurse Aide (CNA) R said, She's going to want salt and pepper for sure along with the cream and sugar substitute. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #77 (R77) Some residents had filled out a handwritten menu with selections of the Always Available Menu. R77 had written Hot Dog x2 on the selective menu card and received two hamburgers with cheese. R41 had written HOT DOG W/MUSTARD on the selective menu card and had received a hamburger. Resident #22 (R22) R22 had a meal tray card which indicated, Extra sauces or gravy to Foods. R22 had dry ground meat without sauce or gravy. Resident #37 (R37) R37 had a meal tray card which indicated, Extra sauces or gravy to Foods. R37 had dry chopped meat without sauce or gravy. Resident #31 (R31) R31 had a meal tray card which indicated, Sauce/gravy on all meats. R31 had dry ground meat without sauce or gravy. During an interview on 2/8/2026 at 1:58 PM, R31 was asked about her meal. R31 replied, They did not give me gravy, so it was too dry. I did not like it and did not eat anything but one sip of milk. R31's meal tray was sitting at her bedside and appeared untouched except approximately 50% of her serving of chocolate muffin had been consumed. Resident #13 (R13) During the breakfast meal observation in the dining room on 2/9/2026 at 8:31 AM, R13 discussed her meal and said it was Ok but I did not get any yogurt. R13 had handwritten yourgut (sic) on her selective menu. R13 continued to explain, They must be out again. R24 was also in the dining room at this time. R24's meal tray card was observed, and it included, Standing Orders: 1 ea (each) Fresh Banana. There was not a banana on R24's tray although other residents were observed to have a banana. R24 said he got a banana every day and would like one. During an interview on 2/11/2026 at 9:30 AM, the Registered Dietitian (RD) K stated, she would expect condiments on the trays and the meal items on the tray cards to be served as written. Resident #4 (R4) Review of R4's MDS assessment dated [DATE], revealed admission to the facility on 7/25/23 with diagnoses including malnutrition, depression and anxiety disorder. R4 scored 3 of 15 on the BIMS assessment reflective of severe cognitive impairment. During an observation on 2/10/26 at 10:14 a.m., Hospitality aide G walked into R4's room and picked up the breakfast tray. R4 had not eaten any of the food from the tray as it was out of her reach. Hospitality aide G walked out of R4's room and did not offer any food or beverage substitutes or alternative menu items. Resident #47 (R47) (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R47's MDS assessment, dated 1/16/26 revealed admission to the facility on 5/16/25 with active diagnoses that included: diabetes mellitus and hip fracture. R47 scored 13 of 15 on the BIMS assessment reflective of intact cognition. During an observation on 2/9/26 at 9:56 a.m., Licensed Practical Nurse (LPN) H walked into R47;'s room and removed the meal tray from R47's bedside. LPN H did not offer any food or beverage substitutes or alternatives menu items On 2/9/26 at 2:00 PM, a confidential group interview was conducted where four residents stated the facility frequently ran out of their preferred food choices including ice cream, yogurt, pudding, cookies, hamburgers, and hot dogs, which are supposed to be on the Always Available food menu. One Confidential Resident (CR) stated due to a medical condition, they required a gluten-free diet and was served a salad for two meals a day, five days per week. When asked what they would prefer instead of a salad, the CR replied, I'm tired of salads, anything but a damn salad. Review of Resident Council Meeting Minutes since March 2025 read, in part: 3/20/25: .New Business – Concerns/Complaints/Grievances: Residents stating their dislikes are listed right on meal ticket and the kitchen still sends their dislikes to them. 4/17/25: .List of old business (unresolved): Residents continue to get their dislikes (meal ticket) for their meal. New Business – Concerns/Complaints/Grievances: .Residents continue getting food that are listed on their dislikes on meal tickets. 11/20/25: .New Business – Concerns/Complaints/Grievances: Kitchen not having food available that residents ask for. Examples: hamburgers, hot dogs, tomato juice, hot chocolate, ice cream, creamer, sweetener . 12/17/25: .List of old business (unresolved): Kitchen continues to run out of items residents want to order. New Business – Concerns/Complaints/Grievances: .Kitchen continues running out of times. Example: hamburgers, ice cream, cottage cheese, hot chocolate, creamer. 1/15/26: .List of old business (unresolved): Kitchen running out of items – not improved. Review of a facility document titled, A La Carte Menu [Facility Name], read, in part: Breakfast Options Available: . yogurt. Lunch & Dinner Options Available: . hamburger or cheeseburger, hot dog. Sides or Desserts: pudding.ice cream, cookies. Review of the facility policy titled, Resident Meal Service, reviewed 7/1/25, read, in part: Each resident shall receive the correct diet, with preferences accommodated as feasible and shall receive prompt meal service and appropriate feeding assistance. the interdisciplinary staff. will assess each resident's nutritional needs, food likes, dislikes, and eating habits. Review of the facility policy titled, Resident Food Preferences, reviewed 7/31/20, read, in part: .Upon the resident's admission, Dietary Manger or designee will identify a resident's food preferences. Whenever possible, the staff and physician will strive to minimize dietary restrictions in order to (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accommodate those preferences. the resident's clinical record (orders, care plan, or other appropriate locations) will document the resident's likes and dislikes and special dietary instructions or limitations. The Food Service Department will offer food substitutes.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review, the facility failed to provide dining adaptive equipment for four Residents (#6, #23, #30 & #48) of five residents reviewed for dining assistive devices. Findings include: During the lunch meal observation on 2/8/2026 at 1:15 PM, four meals did not receive the prescribed special adaptive equipment per the meal tray cards:Resident #6 (R6)R6 had a meal tray card which indicated Adap. Equip: (Adaptive Equipment) 2-handle Cup, Built-Up Utensil Handles, red plate. R6 received plastic silverware but did not receive silverware with built -up utensil handles and did not receive the specialty red plate.Resident #23 (R23)R23 had a meal tray card which indicated Adap. Equip including straws. No straws were observed on R23's tray.Resident #30 (R30)R30 had a meal tray card which indicated Adap. Equip including 2-handled cup, and straw. R30's tray did not include a straw or beverage in a 2-handled cup.Resident #48 (R48)During the breakfast meal observation on 2/9/2026 at 9:01 AM, R48 had a meal tray card which indicated Adap. Equip including 2-handled cup and on the side of the meal tray card contained an ALERT: 2 handled cup FLAT LID. R48's beverage was not served in a 2- handled cup with a flat lid.The facility policy titled Use of Assistive Devices dated as reviewed/revised on 10/26/2023 read in part, The purpose of the policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity. Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities.Assistive devices include:.g. Eating utensils.3. The facility will provide assistive devices for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices.The facility policy titled Resident Meal Service dated as reviewed/revised on 7/1/2025 read in part, Each resident shall receive the correct diet, with preferences accommodated as feasible and shall receive prompt meal service and appropriate feeding assistance. 6. Assistive devices will be made available to residents who need them.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to promote and facilitate resident self-determination through support of resident choice for three Residents (#10, #12, & #30) of three Resident reviewed for resident choice.Findings include: Resident #10 (R10) According to the medical record, R10 was admitted on [DATE] with diagnoses including spastic quadriplegic cerebral palsy (the most severe form of cerebral palsy characterized by extreme muscle stiffness and poor motor control in all four limbs and trunk), need for assistance with personal care, major depressive disorder and chronic pain syndrome. R10's Minimum Data Set (MDS) dated [DATE] contained a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating R10 was cognitively intact. R10's functional status assessment revealed substantial assistance from staff to roll right or left, total dependence on staff to sit from lying down and total dependence on staff to transfer to and from a bed to a chair (or wheelchair). On 2/8/2026 at 2:34 PM, a sign was observed on the outside of R10's door which read, Please wake up by 1 PM. The room was dark and R10 was lying awake in bed. R10 stated, No one has been in yet. I like to get up by 1 (PM) and it is now 2:35 [PM]. During an interview on 2/9/2026 at 2:00 PM, R10 confirmed her desire to get up by 1:00 PM. She stated again she was not up until way after 1:00 today. She said she felt it was because there were not enough staff to help the residents. R10 said, They need more help here. R10 said it was very frustrating that almost every weekend there was not enough staff to provide care. During a telephone interview on 2/9/2026 at 3:18 PM, Certified Nurse Aide (CNA) R said, I feel really terrible but there were not enough people to provide quality care yesterday. She repeated, I feel really bad. CNA R said R10 was supposed to get up by 1:00 and she did not get up until 3 yesterday. CNA R said, She needs two people to get her up and going and there were only 4 CNAs in the building so we could not get to her. The observed workload for 2/9/26 revealed one of the four CNAs was assigned to monitor one resident at all times so the remaining three CNAs were responsible for the other 85 residents. The care plan for R10 was reviewed and the Activities of Daily Living focus had an intervention of, TRANSFERS: Sit-to-Stand lift with 2 person assist. The care plan also included a focus of Resident preferences/quality of life. with an intervention of Honor resident's bedtime preference: (R10) likes to go to bed at 4am and wake up between 1pm -2pm. Date Initiated: 08/08/2023. R10 has submitted multiple grievances to the facility to attempt to solve this issue. On 10/28/25, R10 submitted a type-written letter to the facility stating concerns of not getting up until as late as 4 PM because the nurse wanted to go to lunch and then the hall got really busy. On 1/6/26, R10 presented a typed letter to the facility which stated on 12/27/25 she was not assisted out of bed until after 2 PM. The letter stated, the nurse asked me if I could wait until they (nurse and aide) went to lunch & I said NO because it was already after 2pm. Both solutions of the grievance involved staff education on getting resident up prior to 2 pm. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 (R12) Review of MDS assessment dated [DATE], revealed admission to the facility on 6/7/25 with diagnoses including diabetes mellitus and peripheral vascular disease (PVD) [circulation disorder involving narrowing, blockage, or spasms in blood vessels outside the heart and brain, most commonly affecting the legs and feet] or peripheral arterial disease (PAD) [vascular condition where fatty plaque builds up in the arteries that carry blood to the limbs, usually the legs]. R12 scored 11 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of moderate cognitive impairment. During an interview on 2/9/26 at 9:36 a.m., R12 reported, I have a wound on the bottom on my foot and the nurse will come in during the night or very early in the morning.they wake me up and I can't get back to sleep.I would like the treatment to be done during the day when I am awake. Resident #30 (R30) Review of MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: cancer and arthritis. R30 scored 11 of 15 on the BIMS assessment reflective of moderate cognitive impairment. During an interview on 2/8/26 at approximately 9:38 a.m., R30 reported, The nurse comes in the middle of the night for my roommates dressing change and turns all the lights on, I don't know why they have to turn all the lights on like that.I can't sleep the rest of the night. During an interview on 2/10/26 at 12:35 p.m., Licensed Practical Nurse (LPN)/Unit Manager S reported, I haven't asked R12 what time he would like his dressing change.I schedule them at night. During an interview on 2/10/26 at 12:38 p.m., R12 reported, I have told the nurse before that I didn't want to have the dressing changed at night, but the nurse still changes my dressing in the middle of the night. I would like to sleep through the night. Review of policy titled Pressure Injury Prevention and Management last date reviewed/revised 3/20/24, read in part .Evidence based treatments in accordance with current stands of practice will be provided for all resident who have a pressure injury present.the goals and preferences of the resident.will be included in the plan of care. Review of policy titled Promoting/Maintaining Resident Dignity last dated reviewed/revised 10/26/23, read in part .It is the practice of this facility to protect and promote resident rights.the resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences.

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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 observation, interview, and record review, the facility failed to ensure accurate advanced directive information was in place for one Resident (#11) of two residents reviewed for accuracy of advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time).Findings include:Resident #11 (R11)The Electronic Medical Record (EMR) for R11 revealed an admission on [DATE] with a primary diagnosis of autistic disorder (a lifelong neurological condition characterized by difficulties with social communication, restricted interests and repetitive behavior). The Minimum Data Set (MDS) assessment indicated the Brief Interview for Mental Status (BIMS) assessment could not be completed as the resident was rarely/never understood. The Physician Orders included Full Resuscitation, dated as 8/17/2022. R11's EMR was noted to have a chart banner on each page indicating Code Status: (Advanced Directives) Full Resuscitate.The documents filed in the EMR included a form titled DO NOT RESUSCITATE (DNR) ORDER GUARDIAN CONSENT COURT APPOINTED GUARDIAN MAKING DECISIONS. This form was signed by the Legal Guardian and the Physician on 12/12/2025. There were lines on the form for the attestation of two witnesses with their signatures and these lines were blank.Further documents dated 11/12/2024 signed by the Legal Guardian and the Physician indicated a box checked, I want efforts made to prolong my life and want life sustaining treatment to be provided.During an interview on 2/9/2026 at 3:54 PM, the Social Service Designee/Staff P reviewed the documents that indicated R11 should be resuscitated and others which indicated R11 should not be resuscitated. Staff P said he was not sure if R11 was a full code or a DNR.During an interview on 2/9/2026 at 3:59 PM, License Practical Nurse (LPN) H looked at the banner on the EMR and stated R11 was a full code (and should be resuscitated). She said she thought he had always been a full code. The EMR form titled DO NOT RESUSCITATE (DNR) ORDER GUARDIAN CONSENT COURT APPOINTED GUARDIAN MAKING DECISIONS for R11 was also reviewed and then LPN H stated she did not know what the directive should be. The facility policy titled, Residents' Rights Regarding Treatment and Advance Directives revised on 10/30/2023 read in part: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. 8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to protect the privacy of medical records for one Resident (#99) of one resident reviewed for privacy of medical records.Findings include:During an observation on 2/11/26 at 8:22 a.m., A medication cart at the beginning of C Hall had a facility laptop computer open with R99's personal health information present on the screen with no facility staff present near the medication cart.During an interview on 2/11/26 at 8:23 a.m., Licensed Practical Nurse (LPN) U reported, I know I am not supposed to leave the screen opened with resident information available for anyone to have access to.During an interview on 2/11/26 at 9:38 a.m., the Nursing Home Administrator (NHA) acknowledged medical record information was not secured when the LPN walked away from the medication cart.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to intake #2702621 Based on interview and record review, the facility failed to protect one Resident (#93) of one resident reviewed for misappropriation of property.Findings include:Resident #93 (R93)The facesheet for R93 had an original admission to the facility on 1/29/26 with diagnoses including fracture of the left tibia/fibula (both lower leg bones were broken).According to R93's Minimum Data Set (MDS) dated [DATE], a Brief Interview for Mental Status (BIMS) was completed and a score of 15/15 indicated R93 was cognitively intact.During an interview on 2/8/26 at 2:15 PM, R93 stated a night shift nurse took her pain pills (four hydrocodone 10 milligram (mg)/325 mg acetaminophen a narcotic pain medication) and she was having increased pain and wanted to take one. R93 stated that she brought them into the facility with her when she was admitted from the hospital.R93's inventory sheet, dated 1/28/26, was reviewed and did not list any medications.Review of R93's progress note, dated 2/9/26 at 7:28 AM, entered by the Director of Nursing (DON) read in part Resident had brought a concern to staff at approximately 5:30 on Saturday that she was missing 4 Norco that she had in her purse from home.During an interview on 2/9/26 at 4:50 PM, the DON was asked about the allegation of the missing controlled pain medication and the admission process. When the DON was asked if an inventory of residents' belongings including medication took place, she replied, I know the care assistants inventory the clothing. I am not sure if nurses ask about medications, but that is a good idea going forward.On 2/10/26 at 3:00 PM, the facility Regional Director of Operations (RDO) LL provided a summary of R93's allegation of medication misappropriation which read in part, .On 2/7/26 at approximately 5:15 PM (R93) notified the administrator that she was missing 4 (hydrocodone).The administrator asked if she had any other medications in her purse and she grabbed her purse and presented her with the empty bottle of (hydrocodone), gabapentin, and (ondansetron).On 2/10/26 at 5:00 PM, an interview was conducted with Confidential Family Member (CFM) who expressed concerns with a nurse (Registered Nurse AA) and with facility staffing. CFM went on stating how do two certified nurse aides cover five wings. Staff are leaving because of burn out and the facility is short-staffed. I have no idea what is going on but good staff are leaving. There was a nurse (RN AA) who was terminated because she was asleep over her medication cart and was under the influence of something and refused a drug test. Several staff were concerned on Friday or Saturday morning (2/7/26 and 2/8/26) and stayed over to help other staff until 10 AM because there were not enough staff to assist residents. RN AA just left and it was horrible.During an interview on 2/10/26 at 6:43 PM, with RN X who was asked about RN AA and her condition on 2/7/26 during the day shift and replied, I knew something was going on with her and kept my eye on her. She was not passing medications, and it was 9 or 9:30 AM. I was concerned she was not passing medication down D-Hall. She was acting weird and was weaving and wobbling all over. She moved her cart to C-Hall and was by the alcove. The unit manager came in and called the Nursing Home Administrator (NHA). The cops should have been called right away, and they were not because of the condition she was in. I am not sure if she was under the influence prior to the start of shift or during the shift. She was nervous and not able to stay on task. We had to call the doctor because of medication errors, and I am not sure if residents were getting their pain medications or not. Even the night shift staff were not sure about her and thought she was off.On 2/10/26 at 7:03 PM, an interview was conducted with Certified Nurse Aide (CNA) GG who was working on 2/7/26 day shift with RN AA who replied, I worked on C-Hall with her and talked with her a few times. She could not control her facial movements. I did see her passed out at her medication cart with one arm on her head sitting in a chair in the alcove. She did not give me much response back while talking with her. The NHA came in, they took her medication cart keys, and another aide walked her back to the breakroom. A couple of other staff members were concerned about her driving home. We all thought she was under the influence of something. One resident down C-Hall said she was cooked and wiped (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out. It was pretty evident to everyone that she was under the influence.During an interview on 2/10/26 at 7:17 PM, CNA F who worked with RN AA on 2/7/26 during day shift replied, That was crazy, a lot of crazy! She was bouncing off the walls for support, and she could barely keep her eyes open. She was camping out down by the alcove on C-Hall and did not even pass any medications on D-Hall. It looked like to me that she was strung out on something. She was talking to herself and crawling out of her skin. Her facial movements were uncontrolled. She fell asleep on her medication cart. I went and told one of the nurses about her and they called the NHA. She should not have had keys to the medication cart. She should not have been able to leave the facility. She could barely walk or keep her eyes open. Everyone was at risk! Two residents, one from D-Hall and another from C-Hall both stated that she was cooked. Another resident received the wrong medications.On 2/11/26 at 7:50 AM, an interview was conducted with Confidential Resident (CR) who confirmed how RN AA was behaving like on 2/7/26 during the day shift. CR replied, That nurse was higher than a [NAME]. She was F**ked up. She was hiding in the C-Hall alcove.During an interview on 2/11/26 at 8:13 AM with unit manager LPN W regarding RN AA who replied, I came in about 10:00 AM and worked until 2:00 PM. She was standing at her medication cart restless and in pain. I called the NHA and another nurse took her medication cart keys. She was twitchy.On 2/11/26 at 9:10 AM, an interview was conducted with the NHA who confirmed that RN AA was behaving out of the ordinary and was terminated for refusing a drug test.Review of the summary for R93's missing narcotic medication, dated 2/7/26, read in part 5:15 pm Administrator entered the resident's room to discuss care and resident notified administrator the she was missing 4 Norco's .I had a bottle in my purse with 4 Norco in it and they are gone now. That skinny little nurse probably took them last night .The resident had a inventory upon admission which did not reflect and meds from home . Recovered medications were noted to be hydrocodone (Norco) one, gabapentin 39, and ondansetron 47, which were counted by the Nursing Home Administrator and Licensed Practical Nurse/Unit Manager W.Review of R93's progress note, dated 2/8/26 at 7:00 AM, read in part .On Sunday (2/7/26) at approximately 3:30 PM myself and another nurse went down to the resident's room and ask (sic) if we could look in her purse and her drawers to ensure that they hadn't just fallen out. So with her permission we searched her purse and her room. We did find marijuana gummies in her purse.We also found cigarettes and a lighter in her room.Review of policy titled, Abuse, Neglect, and Exploitation, dated 1/10/2024, read in part Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.

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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 deficient practice pertains to intake #2702621 Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for one resident (Resident #93) out of one resident reviewed for reporting abuse. Findings include:Resident #93 (R93)Face sheet for R93 had an original admission to the facility on 1/29/26 with medical diagnoses including fracture of the left tibia/fibula (both lower leg bones were broken).According to R93's Minimum Data Set (MDS) dated [DATE], a Brief Interview for Mental Status (BIMS) score of 15/15 indicated R93 was cognitively intact.During an interview on 2/8/26 at 2:15 PM, R93 stated a night shift nurse took her pain pills (four hydrocodone 10 milligram (mg) / 325 mg acetaminophen a narcotic pain medication) and she was having increased pain and wanted to take one. R93 stated that she brought them into the facility with her when she was admitted from the hospital.Review of R93's progress note, dated 2/9/26 at 7:28 AM, entered by the Director of Nursing (DON) read in part Resident had brought a concern to staff at approximately 5:30 on Saturday (2/6/26) that she was missing 4 Norco that she had in her purse from home.At the time the administrator and the nurse went down and spoke with her about it.During an interview with the Nursing Home Administrator (NHA) on 2/9/26 at 2:20 PM, who was asked if the allegation of misappropriation of R93's hydrocodone was reported to the state agency (SA) and replied, No.According to the State Agency (SA) report, dated 2/8/26 at 4:47 PM, the misappropriation incident was discovered on 2/7/26 at 5:26 PM indicating late reporting. As reported by R93 to this Surveyor on 2/7/26 at 2:15 PM and this Surveyor alerted the DON on 2/7/26 at 2:20 PM of the misappropriation allegation.Review of policy titled, Abuse, Neglect, and Exploitation, dated 1/10/2024, read in part Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all violations to the Administrator, state agency, adult protective services and to all other required agencies.within specified timeframes as required by state and federal regulations.b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to implement policies and procedures for ensuring investigating of an alleged resident misappropriation of medication for one Resident (#93) out of one resident reviewed for investigation of abuse.Findings include:Resident #93 (R93)The facesheet for R93 had an original admission to the facility on 1/29/26 with medical diagnoses including fracture of the left tibia/fibula (both lower leg bones were broken).According to R93's Minimum Data Set (MDS) dated [DATE], a Brief Interview for Mental Status (BIMS) score of 15/15 indicated R93 was cognitively intact.During an interview on 2/8/26 at 2:15 PM, R93 stated a night shift nurse took her pain pills (four hydrocodone 10 milligram (mg)/325 mg acetaminophen a narcotic pain medication) and she was having increased pain and wanted to take one. R93 stated that she brought them into the facility with her when she was admitted from the hospital.The Director of Nursing (DON) was asked on 2/9/26 at 9:00 AM and 2:30 PM, if there was any documentation of an investigation related to the alleged misappropriation of narcotics and thus far nothing had been provided.During an interview on 2/10/26 at 3:00 PM, Regional Director of Operations (RDO) LL asked if anything was needed and this Surveyor asked if there was an investigation regarding R93's misappropriation of medication. She later returned with a summary of the event.Review of the facility staff interviews dated 2/6/26, 2/7/26, and 2/10/26 and staffing schedule dated 2/7/26, revealed the lack of any interviews with 16 staff members regarding an allegation made by R93's pertaining to misappropriation of her narcotic medication.During an interview on 2/9/26 at 4:50 PM, the DON was asked about the allegation of the missing controlled medication and the admission process. When the DON was asked if an inventory of residents' belongings including medication took place, she replied, I know the care assistants inventory the clothing. I am not sure if nurses ask about medications, but that is a good idea going forward.Review of R93's progress note, dated 2/9/26 at 7:28 AM, entered by the DON read in part Resident had brought a concern to staff at approximately 5:30 on Saturday that she was missing 4 Norco that she had in her purse from home.Review of policy titled, Abuse, Neglect, and Exploitation, dated 1/10/2024, read in part Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.V. Investigation of alleged abuse, neglect and exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include.3. Investigating different types of alleged violations. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.6. Providing complete and thorough documentation of the investigation.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to obtain physician dietary orders for the resident's immediate care for two Residents (#91 & #94) of two records reviewed for admission orders.Findings include: Resident #94 (R94) During an interview on 2/8/2026 at 3:05 PM, R94 was observed in his bed and said, I am mad. I got here Friday and today I did not get breakfast or lunch. I am going to call the administrator. He said he had only had a coffee and donut holes brought in by his visitor and he pointed to the empty disposable coffee cup and empty donut box. R94's roommate stated, I just went down and told the kitchen that he did not get any food today. During an interview on 2/08/2026 at 3:07 PM, Dietary Manager (DM/Staff) C said, I guess he got here yesterday. I will deliver it. A review of the Electronic Medical Record (EMR) revealed R94 was admitted to the facility on [DATE] at 5:31 PM. The Physician Orders contained a diet order for R94 dated 2/8/2026 at 3:27 PM. The diet notification/transmittal sent to the dietary department from the nursing department for R94 was dated 2/8/2026. Resident #91 (R91) The facesheet for R91 had an original admission to the facility on 2/6/26. According to R91's minimum data set (MDS) dated [DATE], a brief interview for mental status (BIMS) score of 15/15 indicated R91 was cognitively intact. During an interview on 2/9/2026 at 11:00 AM, R91 was observed in her bed and said, I got here Friday and Saturday I did not get any lunch and today (2/8/26) I did not get breakfast. It is now lunch time. I am not even sure I will get lunch. They treat animals at the zoo better than this! A review of the EMR revealed R91 was admitted to the facility on [DATE] at approximately 17:25 (5:25 PM). The Physician Orders contained a diet order for R91 dated 2/8/2026 at 15:29 (3:29 PM). The diet notification/transmittal sent to the dietary department from the nursing department for R91 was dated 2/8/2026. Review of facility document titled, (Facility name) admission Check Off, undated, revealed an indication for nursing to add a diet order upon admission. On 2/10/26 at 4:00 PM, an interview was conducted with Registered Nurse (RN) N, who was asked about the admission process which included a confirmation of a diet order being added upon admission. On 2/10/26 at 4:20 PM, an interview was conducted with the Director of Nursing (DON), who acknowledged a diet order should be written upon admission and dietary should be alerted. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Orders – Admission, dated 1/30/2024, read in part Policy: A physician must personally approve, in writing, a recommendation that an individual be admitted to a facility. A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide orders for the residents' immediate care needs. Policy explanation and compliance guidelines: 1. The written orders should include at a minimum: a. admission to the facility, b. Diet orders.2. The orders should allow facility staff to provide essential care to the resident.

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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** This deficient practice pertains to intake 2702621Based on observation, interview, and record review, the facility failed to ensure residents were provided individualized care to promote dignity and enhance their quality of life for three Residents #4 (R4), #47 (R47) and #93 (R93) of five residents reviewed for ADL's.Findings include: Resident #4 (R4) Review of Minimum Data Set (MDS) assessment dated [DATE] revealed admission to the facility on 7/25/23, with active diagnoses that included: depression, anxiety disorder, malnutrition, and osteoporosis. Further review of MDS Section GG, required staff to provide R4 supervision/touching assistance for turning or repositioning in bed. Further review of the MDS Section M revealed R4 was at risk of developing pressure ulcers. During an observation on 2/10/26 at 8:30 a.m. until 10:30a.m., R4 was laying on her back in her bed with the head of the bed slightly elevated. None of the staff went into the room to assist R4 to turning/repositioning in bed or encourage R4 to turn or reposition for two hours. Resident #47 (R47) Review of R47's MDS assessment, dated 1/16/26 revealed admission to the facility on 5/16/25 with diagnoses including diabetes mellitus and hip fracture. R47 scored 13 of 15 on the BIMS assessment reflective of intact cognition. During an observation and interview on 2/8/26 at 12:38 p.m., R47 was lying in bed and was noted to have long facial hair. When queried about his facial hair R47 reported, he had not had a shave in quite a while and stated he could not recall when the last time he had not been shaved. During an interview on 2/10/26 at 1:32 p.m., Certified Nurse Aide (CNA) E reported, The residents are supposed to be shaved when they are admitted to the facility, on the day they receive their shower, or when they request to be shaved. During an interview on 2/10/26 at 1:34 p.m., R47 reported, I would like to be shaved, the staff has not shaved me in such a long time.when my facial hair is long it makes me feel dirty. During an interview on 2/10/26 at 2:23 p.m., CNA F" reported, There are times we can't take care of the residents and they don't get the care they deserve.We don't have enough staff here and the residents are neglected. Resident #93 (R93) The facesheet indicated R93 was originally admitted to the facility on [DATE] with diagnoses including fracture of the left tibia/fibula (both of the lower leg bones were broken), diabetes mellitus, and chronic kidney disease requiring dialysis (a treatment where blood is filtered of waste and excess fluid by a machine). According to the MDS dated [DATE], R93 had a BIMS score of 15/15 indicating R93 was cognitively (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intact. The MDS assessment indicated R93 was dependent on staff for bathing and required the assistance of two staff, and required one staff assist for toileting. During an interview on 2/9/26 at 12:10 PM, R93 voiced, yesterday morning she had been left wet and soiled in her urine and fecal matter for an extended period of time that lasted over two hours. R93 described the experience as mortifying and it felt nasty. On 2/10/26 at 2:15 PM, an interview was conducted with R93 regarding personal hygiene and replied, I have not received a shower since I got here, and I have been here for two weeks. The staff hardly get me up in my chair. R93 was observed at the time to have disheveled hair. R93's preferences for customary routine and activities, dated 1/29/26 revealed it was very important to her to be able to choose between a tub bath, shower, bed bath, or sponge bath and chose to have showers. The care plan for R93, dated 1/29/26 read in part, .Focus: Resident has an ADL (activities of daily living) self-care performance deficit related to chronic kidney disease, COPD (chronic obstructive pulmonary disease), recent fractures. Goal: Resident's.ADL needs will be met through the next review date. Interventions. Interventions did not include bathing. Review of R93's progress notes, dated 1/29/26 through 2/9/26, revealed she was sent to the local hospital on 2/1/26 and later returned to the facility on 2/4/26. On 2/9/26 at 8:55 AM, an interview was conducted with CNA V, who was asked if R93 had received any showers since being admitted to the facility on [DATE] and replied, No, I do not have any shower sheets for her. Her (R93's) shower days are Wednesday and Saturday. A lot of the times no showers are completed on Saturday because of call-ins. During R93's task list for showers dated 1/29/26 through 2/10/26 it was discovered R93 did not receive a shower on 1/31/26 (Saturday), 2/4/26 (Wednesday), or 2/7/26 (Saturday). Review of policy titled Promoting/Maintaining Resident Dignity last reviewed/revised 10/26/23, read in part .It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity .each resident will be provided equal access to quality care. Review of policy titled Activities of Daily Living last reviewed/revised 12/28/23, read in part .This facility takes measures to minimize the loss of resident functional abilities including.the ability to bathe, dress, and groom.A resident who is unable to carry out activities of daily living receives the necessary services to maintain.grooming and personal and oral hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2702621.Based on observation, interview and record review, the facility failed to initiate bowel protocol in a timely manner for two Residents (#25 and #69) and failed to complete an assessment upon admission for one Resident (#91) of three residents reviewed for quality of care. Findings include:Resident #91 (R91) The facesheet for R91 had an original admission to the facility on 2/6/26. According to R91's minimum data set (MDS) dated [DATE], a brief interview for mental status (BIMS) score of 15/15 indicated R91 was cognitively intact. On 2/8/26 at 2:33 PM, R91 provided a notebook where she had been writing about her experience at the facility since her admission on [DATE] at approximately 6:20 PM. R91 had written she was told dinner was on the way and at 7:15 PM still did not get dinner on 2/7/26. During her arrival staff scurried in, did a few things and flew back out of her room. R91 stated, I had no idea what was happening with the staff and there I was just lying in bed. No vital signs were taken at the time of my admission, no blood pressure, no assessment or anything else. I needed pillows to elevate my legs to prevent bed sores and reduce swelling. I just sat there in total silence. R91 made a note she had put her call light on during Friday night and it was on for quite a spell. R91 noted that no staff came for quite some time and she was scared and upset over having to stay at the facility. R91 laid in bed wondering if something happened at the facility. R91 was unable to move because of the recently broken leg she was admitted to the facility with. R91 felt helpless as her call light continued to be on without being answered. R91 then got her cell phone out and looked up the phone number to the facility after she thought about calling the police. R91 called the facility, the phone was answered but not by staff. R91 stated, The facility phone had been answered by a resident who was living at the facility. I could not believe another resident had answered the phone. It was a female resident who remarked 'it's for you' and the phone was handed over to a male resident, who promptly asked 'who is this?'. That was the last straw! I was completely thrown off guard and lost it. I really thought there was an emergency somewhere in the building or it had been taken over! What a mess! Finally, a female staff came to my room, and I told her what had just happened with the phone and the female staff person just looked at me with a blank look. I gave the female staff a chance to answer me and the staff finally said 'wow, I could not make that story up if I wanted to.' I agreed. I put my call light on in the early morning of 2/9/26 at approximately 2:00 AM and it was not answered until 55 minutes later to help me to the bathroom. A review of the EMR revealed R91 was admitted to the facility on [DATE] and a nursing assessment had been started on 2/7/26 at 12:10 AM nearly six hours later which was not completed. Review of policy titled, Orders – Admission, dated 1/30/2024, read in part Policy: A physician must personally approve, in writing, a recommendation that an individual be admitted to a facility. A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide orders for the residents' immediate care needs. Policy explanation and compliance guidelines: 1. The written orders should include at a minimum: a. admission to the facility, b. Diet orders.d. Other care related orders. 2. The orders should allow facility staff to provide essential care to the resident. On 2/10/26 at 4:00 PM, an interview was conducted with Registered Nurse (RN) N who was asked about the admission process and replied, Right away as nurses we settle the resident in the room, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	add a diet order, do an assessment from head to toe, get a set of vital signs, skin assessment, let the doctor know, and write a note in the chart about the admission. RN N was asked when this was completed and replied, Oh well, when the resident first arrives. During an interview with Senior Director of Nursing (DON)/RN CC on 2/10/26 at 4:20 PM who confirmed that nursing staff is to complete and assessment within the first hour of an admission and a set of vital signs is expected immediately. Resident #25 (R25) Review of the electronic medical record (EMR) revealed R25 was admitted to the facility on [DATE] and had diagnoses including diabetes, Stage 2 sacral pressure ulcer, left hip fracture, mesenteric artery stenosis (narrowing of the artery supplying blood to the intestines) and constipation. On 2/8/2026 at 12:58 p.m., R25 was observed lying in bed with family member (FM) QQ at the bedside. When asked if he had any concerns, R25 reported he had not had a bowel movement in the past four days, and he was concerned he had not been provided with treatment. R25 was observed placing his left hand on his abdomen and reported he was beginning to feel uncomfortable. When asked if staffing was aware, R25 reported he had alerted nursing the previous day. FM QQ reported she had also alerted nursing staff the previous day concerning R25 not having had a bowel movement, but no treatment had been provided. On 2/9/2026 at 11:23 a.m., R25 was observed lying in bed with FM QQ at the bedside. R25 reported he was yet to have a bowel movement and still had not received treatment. When asked how he was feeling, R25 reported, difficult to describe . nauseous with abdominal discomfort. FM QQ reported a nurse was just in the room to review how he was feeling since admission. FM QQ reported she alerted the nurse that R25 had not had a bowel movement in more than four days, and the nurse reported she was going to call the physician regarding the Resident's condition. FM QQ did not know the name of the nurse she had spoken to. During an interview on 2/9/2026 at 5:03 p.m., Licensed Practical Nurse (LPN) U reported he was alerted by Unit Manager/LPN W earlier this day, R25 had not had a bowel movement since admission on [DATE]. LPN U reported LPN W met with the Resident and FM QQ and treatment was requested. LPN U stated he would be taking care of it. When asked how residents were assessed for bowel health, LPN U reported nursing staff were usually given a list of residents in the morning by the Unit Managers, of those requiring initiation of bowel protocol. LPN U reported he had not received a list this day and was unaware of R25's condition until reported by LPN L, R25 required treatment. Review of R25's February 2026 point of care (POC) documentation for Bowel Elimination, accessed on 2/10/2026 at 8:43 a.m., revealed No bowel movement documented from the date of R25's admission on [DATE] through 2/10/2026 at 3:35 a.m., with no further documentation on 2/10/2026 after 3:35 a.m. Review of R25's physician orders, accessed 2/10/2026 at 8:51 a.m., revealed R25 was prescribed hydrocodone-acetaminophen (opioid pain medication) 5-325 mg (milligram) with directions to give one tablet by mouth every 6 hours as needed for pain. Review of the February 2026 Medication Administration Record (MAR) revealed R25 had been administered the pain medication on 12 occasions since admission on [DATE] through the date of review on 2/10/2026. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The February MAR also revealed the following medication orders: Milk of Magnesia Suspension [bowel stimulant]. Give 30 ml [milliliter] by mouth every 72 hours as needed for constipation if no bowel movement in 3 days . Start date: 2/06/2026 [4:40 p.m.]. It was noted one dose was documented as administered by LPN U on 2/09/2026 at 5:25 p.m., on day five of no bowel movement for R25. Dulcolax Suppository [bowel stimulant]. Insert 1 suppository rectally as needed for constipation if no result from Milk of Magnesia . Start dated: 2/06/2026. It was noted no doses of the medication were documented as administered. Fleet Enema [bowel stimulant]. Insert one unit rectally as needed for no result from Dulcolax, administer fleet enema daily [as needed] for constipation. Start date: 2/06/2026. It was noted no doses of the medication were documented as administered. Miralax [laxative medication] Oral Packet 17 GM. Give 1 packet by mouth one time a day for constipation. Start dated: 2/10/2026 [6:00 a.m.]. One dose was documented as administered on 2/10/2026 at 6:00 a.m. Colace [stool softening medication] Oral Capsule 100 MG. Give 1 capsule by mouth one time a day for constipation. Start date: 2/10/2026 [6:00 a.m.]. One dose was documented as administered on 2/10/2026 at 6:00 a.m. It was noted in review, the scheduled daily laxative medication and stool softener were not ordered until more than five days after R25's admission and after consistent administration of the opioid medication. Resident #69 (R69) Review of the MDS assessment, dated 1/24/2026, revealed R69 was admitted to the facility on [DATE] with diagnoses including demyelinating disease of the central nervous system, osteoporosis, arthritis, generalized weakness and frequent falls. The MDS indicated R69 required set-up assistance only with eating, substantial/maximal assistance with sitting to standing and partial/moderate assistance with chair/bed-to-chair transfers. R69 scored 13 out of 15 on the BIMS, indicating the Resident had mild cognitive impairment. On 2/9/2026 at 10:10 a.m., R69 was observed lying in bed with a pink emesis basin lined with plastic positioned on the floor near the head of her bed. R69 reported she was not feeling well and was nauseous. Certified Nursing Assistant (CNA) L was present at the time of the observation and asked R69 if she was going to eat breakfast. R69 declined her breakfast at that time and stated, my stomach is not doing so well. On 02/9/2026 at 1:51 p.m., R69 was observed seated in a wheelchair in her room. R69 reported she continued to feel not well. R69 reported she did not eat lunch due to continued nausea. When asked if she had regular bowel movements, R69 stated, that could be it, and reported she was unsure when her last bowel movement was. During an interview on 2/9/2025 at 5:03 p.m., LPN U reported he was unsure when R69's last bowel movement was and was also unaware of R69's reports of nausea this day. LPN U reported R69's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition was declining and she was recently referred for hospice services. When asked if bowel health contributed to quality of life, LPN U stated, definitely it does. Review of the February POC documentation for Bowel Elimination, accessed on 2/10/2026 at 9:30 a.m., revealed R69's last bowel movement was documented on 2/05/2026 at 4:32 p.m. Subsequent documentation revealed No bowel movement, recorded from the date of R69's last bowel movement on 2/05/2026 through the date of review on 2/10/2026. It was noted R69 had not had a bowel movement in more than three days. The EMR revealed R69 had no documentation of a bowel assessment to correspond with the reports of nausea on 2/9/2026 or relation to no bowel movement in more than three days. Review of the February 2026 MAR revealed the following active medication orders: Milk of Magnesia Suspension 400 mg/5 ml. Give 30 ml by mouth every 72 hours as needed for constipation at bedtime if no BM [bowel movement] in 3 days. Start dated: 7/10/2025. It was noted no doses were documented as administered for February 2026. Metamucil Oral Powder 38.57%. Give 3.4 gram every 24 hours as needed for constipation. Start dated: 11/20/2025. It was noted no doses were documented as administered for February 2026. Dulcolax Suppository. Insert 1 suppository rectally as needed for constipation. If no result from Milk of Magnesia administer Dulcolax suppository rectally at bedtime for constipation. Start date: 7/15/2025. It was noted no doses were documented as administered for February 2026. Fleet enema. Insert 1 unit rectally as needed for no result from Dulcolax, administer fleet enema daily [as needed] for constipation. Start date: 7/15/2025. It was noted no doses were documented as administered for February 2026. During an interview on 2/10/2026 at 10:07 a.m., the Director of Nursing (DON) reported the process for monitoring residents for bowel elimination was for night shift nursing staff to pull a report of resident's bowel elimination history and pass along the information in morning meeting to the oncoming nursing staff. The DON was informed of LPN U's reported that he did not a receive a report of residents for initiation of bowel protocol on 2/9/2026, the DON reported the reports are not consistently provided and the Unit Managers have been running the reports for the nursing staff. The DON stated LPN U did not receive the report because the facility had several new admissions over the weekend and they were busy completing admission orders and documentation. The DON was asked for the facility policy on assessment of bowel elimination and bowel protocol. The DON reported the facility did not have a policy related to bowel protocol as the orders for initiation were clear.

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	235292	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste. Marie	1011 Meridian Road Sault Ste. Marie, MI 49783

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide restorative therapy services for two Residents (#15 & #83) of two Residents reviewed for restorative therapy needs.Findings include:Resident #83 (R83) On 2/8/2026 at 2:50 PM, an observation of R83 revealed she was sitting in a reclined position in bed with her meal tray in front of her. R83 said she had just finished lunch and was fed by staff. When asked about her left contracted hand, R83 stated staff do not work with her on it, and she is supposed to have a brace on but it is the weekend, so nothing is happening. On 2/10/2026 at 12:37 PM, during a follow-up interview, R83 stated she was not getting restorative therapy and had not had it for a long time. R83 stated she was supposed to have a splint for her hand, and she needed assistance putting it on. R83 said, They do not put it on enough. During an interview on 2/10/2026 at 12:34 PM, Certified Nurse Aide (CNA) TT stated, the Restorative Aide put on the splints and did the restorative programs. CNA TT said, The CNAs do not do restorative unless we have time, and we don't usually have time. During an interview on 2/10/2026 at 12:36 PM, CNA J said there was a Restorative Aide who did Restorative. CNA J said, the CNAs did not do Restorative. According to the medical record, R83 was admitted on [DATE] with medical diagnoses including quadriplegia (paralysis affecting all four limbs and the torso), anoxic brain damage (damage from a shortage of oxygen to the brain), and need for assistance with personal care. R83's Minimum Data Set (MDS) dated [DATE] contained a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating intact cognition. R83's functional status assessment revealed total dependence from staff to roll right or left, total dependence of staff to lie down from sitting, and total dependence on staff to sit from lying down. The functional limitation in range of motion was assessed as impairment on both sides of upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). Section O of the MDS also noted in the last 7 calendar days only one day had at least 15 minutes of passive range of motion (ROM) recorded and one day of splint or brace assistance. The Care Plan for R83 included a focus plan of, Resident would benefit from a restorative range of motion program PROM (Passive Range of Motion to) shoulder, left elbow and fingers and BLE r/t (Bilateral Lower Extremities regards to) stiffness Date Initiated: 03/13/2024 with a Goal for this plan of, Resident will tolerate their range of motion program with no evidence of pain through the next review. Target Date 3/23/2026. Interventions for this plan included, .perform PROM stretching (5-10 seconds each x 2) to both shoulders, and to left elbow and fingers to prevent progression of contracture and to relieve stiffness. Gentle PROM on BLE 10 reps x 3 (all major planes) Date Initiated: 12/23/2024. The Care Plan for R83 further included a focus plan of, Resident would benefit from a restorative splinting program related to limitation in range of motion Date Initiated: 12/23/2024. The Goal for this plan included, Resident will have reduced complications related to splint use through the next review. Target Date 03/23/2026. Interventions for this plan included: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident prefers to not have splint reapplied on the day she removes it herself, continue to monitor Date Initiated: 02/05/2025 . wash left hand with soap and water, rinse, pat dry prior to splint application Date Initiated: 02/05/2025 Provide splinting program: [NAME] (put on) palm protector splint to left hand for 3-4 hours of wear time. Revision on 12/23/2024 The medical record included the CNA task list for documentation of treatment as given. The most recent 14-day period was reviewed. For the task: Maintenance Restorative Nursing: Splint/Brace Assistance (12h) [NAME] palm protector splint to left hand for 3-4 hours of wear time. Check skin after doffing (taking off) for redness or irritation. There were only two days when brace toleration was documented. All other days were documented as Did not occur. The current Physician Orders were reviewed. There were no orders for a restorative therapy program or orders for splint/brace use. During an interview on 2/10/2026 at 12:58 PM, the Director of the Therapy Department/ Staff UU described the interaction between the therapy department and the nursing department. Staff UU said when a resident is discontinued from therapy and will be staying to live at the facility, a plan is made for that resident. Staff UU said, We write up our recommendations for restorative and send a copy to nursing . an RN (Registered Nurse) should enter it (into the medical record) and the restorative aide will follow up. Staff UU reviewed her documentation and stated R83 was on the restorative list. During an interview on 2/10/2026 at 1:20 PM, the Senior Director of Nursing (DON) CC stated the facility was reorganizing their staff. DON CC said, We just got people in their roles in the past six months. We do not have a Restorative Nurse yet only a Restorative Aide. The Restorative Aide position was explained as a Monday – Friday position. DON CC stated the restorative program should be happening 7 days a week. When asked about the Restorative Aide, DON CC stated she currently had a medical incident and could not work. When asked who completed the restorative tasks on the weekend or when the current Restorative Aide was off, DON CC replied No one. During this interview on 2/10/2026 at 1:20 PM, the Senior Director of Nursing (DON) CC and the DON reviewed the medical record for R83. No Physician's Order for a restorative regime was found. DON CC stated R83 should have a Physician's Order for a brace or a splint and skin checks. Resident #15 (R15) Review of MDS assessment dated [DATE], revealed admission to the facility on 9/13/24, with active diagnoses including paraplegia [a medical condition involving impairment or loss of motor and/or sensory function in the legs]. R15 scored a 15 of 15 in the BIMS assessment reflective of intact cognition. During an interview on 2/8/26 at 4:46 p.m., R15 reported he used to receive range of motion exercises from the restorative nursing department, and he does not receive those services. R15 reported his ability to use his arm and hands to feed himself is becoming more difficult and he is having a hard time holding the spoon and bringing it to his mouth. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled Restorative Nursing Programs date reviewed/revised 1/1/22, read in part .The goal of restorative nursing includes improving and/or maintaining independence in activities of daily living [essential routine tasks individuals must perform daily-typically eating, bathing, dressing, toileting,, continence, and transferring] and mobility.each facility should establish a monitoring program to assure success

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2702621.Based on observation, interview, and record review, the facility failed to implement fall interventions for one Resident #6 of six residents reviewed for falls and ensure the safety of one Resident #12 for smoking of three residents reviewed for smoking.Findings include:Resident #6 (R6) Review of Minimum Data Set (MDS) assessment dated [DATE] revealed admission to the facility on 4/25/25, with diagnoses including seizure disorder or epilepsy, fracture, and anxiety disorder. R6 scored 9 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of moderate cognitive impairment. During an observation on 2/9/26 at approximately 9:28 a.m., R6 was in bed with his bed in a high position and two floor mats [a specialized shock-absorbing safety device placed on the floor beside a resident's bed to reduce the impact and risk of injury from falls] were folded behind the chair in R4's room. Review of R4's Care plan revealed Focus area resident is at risk for falls/injury.Intervention.fall mats placed on both sides of resident's bed. Date initiated 5/23/25. During an interview on 2/10/26 at 11:53 a.m., Certified Nurse Aide (CNA) OO reported she had started her shift that morning at 6 a.m. and the floor mats were not on the floor by the residents bed.the floor mats are supposed to be on both sides of his bed as an intervention from a previous fall.it should be in his care plan and assigned to us as a task to complete .I cannot view his care plan on the computer. During an interview on 2/10/26 at 12:02 p.m., Registered Nurse (RN) Q acknowledged the bed mats are supposed to be on both sides of the bed as noted in his care plan.This intervention is not set as a task for the CNA's so that is probably why it is not being done.that is concerning when we have so many new staff that don't know these residents. During an interview on 2/11/26 at 9:38 a.m., Nursing Home Administrator (NHA) acknowledged concern regarding floor mat intervention not being in place for R6. Review of policy titled Fall Prevention Program date reviewed/revised 10/26/23, read in part .Each resident will be assessed for the risk of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls.each residents risk factors and environmental hazards will be evaluated when developing the residents comprehensive plan of care. Interventions will be monitored for effectiveness.the plan of care will be revised as needed. Resident #12 (R12) A review of the MDS assessment dated [DATE], revealed admission to the facility on 6/7/25 with diagnoses including difficulty walking, need for assistance with personal care, and tobacco use. R12 scored 11 of 15 on the BIMS assessment reflective of moderate cognitive impairment. On 2/9/2026 at 5:10 PM, CNA C was observed entering the security code to unlock the facility entry door to let R12 back into the building. R12 was observed with a heavy coat, gloves and a dusting of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	snow. CNA C was asked why R12 was outside as the temperature was 17 degrees with strong winds making it feel even colder. CNA C stated, He goes out to smoke. He is his own person. He is supposed to go off the premises. When questioned how that could be as snow was approximately three feet deep on the ground with three to four inches of snow covering the sidewalk, driveway and roads, CNA C said, Well, in the summer he goes across the street. The snow piles on the side of the driveway and roads from the snowplows were approximately 6 to12 feet tall. When R12 was asked where he went to smoke, he stated he just smoked outside the door in the winter as his wheelchair could not move through the snow. During an interview on 2/9/2026 at 5:17 PM, RN N acknowledged R12 went outside to smoke. RN N stated, He smokes as often as he can. He probably goes out about every two to four hours. She stated R12 had his own cigarettes and lighter. Other staff nearby confirmed R12 went out to smoke many times every day. The staff stated he was supposed to sign himself out with the sign out book in the lobby. As we spoke, the sign out book was not in the lobby. On 2/9/2026 at 5:27 PM, the NHA and the Director of Nursing (DON) were approached to discuss the smoking status of R12. The NHA was holding the sign out book along with a lighter and cigarettes. When asked if the lighter and cigarettes were R12's, she said yes, she had just acquired them. The NHA stated the facility was a non-smoking campus and residents could smoke off premises and they should sign out using the sign out book. Upon inspection of the sign out book, the top page had four signatures on the page, all belonging to R12. R12 had signed out on 12/23/25, twice on 12/24/25 and 2/9/26 at 4:50 PM (37 minutes prior to the interview.) The NHA and DON acknowledged R12 was to smoke off campus. They stated other options have been tried but he continues to smoke. The facility policy titled Smoking / Non-Smoking Policy was dated as Reviewed/Revised on 3/12/2022. This policy read in part, It is the policy of this facility to establish and maintain safe resident smoking practices for a non-smoking campus. 1. Prior to, or upon admission, residents shall be informed that smoking is not permitted inside of the facility or outside of the facility on any facility property. C. Residents with smoking privileges may not be permitted to retain any types of smoking articles, to include cigarettes, tobacco, etc., either on his or her person or within his/her living or sleeping area, at any time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to attempt the use of non-pharmacological interventions prior to administration of PRN (as needed) opioid pain medications for two Residents (#8 & #15) of five residents reviewed for unnecessary medications.Findings include:Resident #8 (R8)Review of the Minimum Data Set (MDS) assessment, dated 12/24/2025, revealed R8 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, adjustment disorder with mixed anxiety and depressed mood, spinal stenosis, muscle weakness, and a history of falling.Review of R8's physician orders revealed the following: Oxycodone-acetaminophen [opioid pain medication] Oral Tablet 5-325 MG [milligram]. Give 1 tablet by mouth every six hours as needed for pain. Start Date: 1/21/2026 [1:45 p.m.].Review of R8's February 2026 Medication Administration Record (MAR), located in the electronic medical record (EMR), revealed R8 was administered doses of the ordered oxycodone-acetaminophen 5-325 mg on the following dates/times:2/1/2026 at 12:00 a.m.2/2/2026 at 9:46 a.m.2/3/2026 at 12:24 p.m. and 6:24 p.m.2/4/2026 at 4:36 a.m., 1:38 p.m. and 7:47 p.m.2/5/2026 at 12:52 p.m. and 10:13 p.m.2/6/2026 at 9:18 a.m. and 11:38 p.m.2/9/2026 at 8:01 a.m. and 9:13 p.m.2/10/2026 at 8:59 a.m.The February 2026 MAR revealed no documentation of the location of R8's pain or non-pharmacological interventions attempted and failed prior to the administration of opioid pain medication.The EMR for R8, including progress notes and assessments/evaluations, revealed no documentation of non-pharmacological interventions attempted to correspond with the administered doses of the opioid pain medication.Review of R8's care plan revealed the following: Resident is at risk for pain . Date initiated: 2/18/2025 . Offer non-pharmacological interventions to relieve pain and observe for effectiveness. Date initiated: 2/18/2025.Resident #15 (R15)Review of the MDS assessment, dated 12/31/2025, revealed R15 was admitted to the facility on [DATE] and had diagnoses including cervical disc disorder, schizophrenia, constipation and pain.Review of R15's physician orders revealed the following: Oxycodone-acetaminophen Oral Tablet 10-325 MG. Give 1 tablet by mouth every 4 hours as needed for pain. Start dated: 11/18/2024 [6:15 p.m.].Review of R15's February 2026 Medication Administration Record (MAR), located in the electronic medical record (EMR), revealed the Resident was administered doses of the ordered oxycodone-acetaminophen 10-325 mg on the following dates/times:2/1/2026 at 5:08 a.m., 9:19 a.m., 1:36 p.m. and 8:19 p.m.2/2/2026 at 3:35 a.m., 7:37 a.m. and 2:17 p.m.2/3/2026 at 7:11 a.m., 1:36 p.m. and 6:55 p.m.2/4/2026 at 4:04 a.m. and 12:27 p.m.2/5/2026 at 12:59 a.m., 5:51 a.m., 10:13 a.m. and 7:23 p.m.2/6/2026 at 3:26 a.m., 2:54 p.m. and 7:41 p.m.2/7/2026 at 1:37 a.m., 5:44 a.m., 1:52 p.m. and 9:09 p.m.2/8/2026 at 4:57 a.m., 12:36 p.m. and 6:51 p.m.2/9/2026 at 11:29 a.m.2/10/2026 at 3:10 a.m., 9:33 a.m. and 1:36 p.m.The February 2026 MAR revealed no documentation of the location of R15's pain or non-pharmacological interventions attempted and failed prior to the administration of opioid pain medication.Further review of R15's EMR, including progress notes and assessments/evaluations, revealed no documentation of non-pharmacological interventions attempted to correspond with the administered doses of the opioid pain medication.Review of R15's care plan revealed the following: Resident has pain . Date initiated: 5/13/2024 . Offer non-pharmacological interventions to relieve pain and observe for effectiveness. Date initiated: 5/13/2024. Resident has a history of substance abuse [sic] disorder. Date initiated: 11/07/2024 . Explore alternative methods of coping and offer emotional support as needed. Dated initiated: 11/07/2024.During an interview on 2/10/2026 at 3:29 p.m., the Director of Nursing (DON) reported her expectation was that prior to administration of PRN opioids, non-pharmacological interventions should be attempted and documented in the EMR along with the effectiveness of the intervention. The DON confirmed the lesser of means should be utilized for treating pain to ensure medications are not unnecessarily administered.Review of the facility policy titled, Unnecessary Drugs - Without Adequate Indication for Use, dated 10/26/2023, revealed the following: Indications for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use is the identified, documented, clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with . clinical standards of practice . The indications for initiating, withdrawing or withholding medication(s), as well as the use of nonpharmacological approaches, will be determined by assessing the resident's underlying condition . Documentation will be provided in the resident's medical record to show adequate indications for the medications use . The interdisciplinary team with evaluate the resident to identify his/her needs, goals, comorbid conditions and prognosis to determine factors that are affecting signs, symptoms . nonpharmacological approaches when deciding on medication discontinuation of current medication.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure implementation of physician orders for hospice services for one Resident (#8) and communication with hospice providers and receipt of hospice documentation for one Resident (#4) of two residents reviewed for hospice services.Findings include: Resident #8 (R8) A review of the Electronic Medical Record (EMR) for R8 on 2/9/2026, revealed a physician's order for Hospice consultation dated 1/21/26. The EMR also included a Social Services Progress Note dated 1/28/2026 3:34 PM which read, Note Text: This writer reached out to the guardian in order to provide hospice services through (name of Hospice Organization). Guardian consented to hospice consultation. Referral issued. No hospice consultation follow-up was found in the EMR. On 2/9/2026 at 5:06 PM, the hospice consultation results were requested from the Nursing Home Administrator (NHA). On 2/10/2026 at 8:00 AM, the hospice consultation results were requested from the Director of Nursing (DON). During an interview on 2/10/2026 at 9:20 AM, the DON stated, There is no documentation of the hospice consult. I do not know when they visited. Social Services is getting the follow up email. During an interview on 2/10/2026 at 9:24 AM, Social Services Designee (Staff P) was asked about collaboration with hospice services. Staff P replied, I do not know when hospice is in the building. I'm pretty much in the dark. Staff P stated, They (Hospice Staff) came in for (R8) and I did not know. Staff P said he would be getting the results of the consult and stated, I did not know the results yet. They are sending me an email right now on the results. Resident #4 (R4) Review of R4's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 7/25/23 with active diagnoses that included: malnutrition, depression and anxiety disorder. R4 scored 3 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. Further review of MDS Section O revealed R4 was receiving hospice. Review of document titled Hospice Certification and Plan of Care for R4 dated 12/27/25, read in part .Frequency/Duration of Visits. SN (Skilled Nurse) weekly.Masters Social Work (MSW) one evaluation to assess psychosocial needs, HHA (Home Health Aide) effective 1/4/26 weekly. During an interview on 2/10/26 at 10:44 a.m., Senior Director of Nursing (DON) CC reviewed R4's Electronic Medical Record (EMR) and reported, there is no documentation from hospice regarding the weekly visits for R4. Senior (DON) CC acknowledged a lack of communication from the hospice staff. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Hospice binder on 2/10/26 at approximately 10:46 a.m., revealed no communication from the MSW or HHA. Further review of documentation revealed no communication regarding any visits from the SN from 12/28/25 to 1/8/26 and no communication regarding any visits from the SN between 1/10/26 and 1/21/26. During an interview on 2/10/26 at 10:52 a.m., Social Services Assistant (SSA) MM reported the hospice Social Worker should have left an evaluation in the hospice binder and a SN should have placed any communication to staff in the binder and acknowledged the SN did not make weekly visits. Review of policy titled Hospice date reviewed/revised 10/26/23, read in part .the facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the residents care.