STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235293	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Farmington	34225 Grand River Ave Farmington, MI 48335

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #s: 2608297, 2629174, 2639760, 2658977. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, safe, and homelike environment, affecting all 83 residents throughout the facility, including R8, R9, R30, R41, R43, R48, R56, R58, R59, R60, R64, R73, R78, R89, and five of 12 residents that attended the confidential resident council meeting. Findings include: On 1/26/26 at 10:25 AM, R56 was observed lying upon worn, ripped, stained, unclean fitted sheets. The bed frames were observed with dried substance matter along the perimeter of the mattress. The tube feeding pump, pole, and base was observed with dried splattered brown colored matter. Below the headboard revealed piles of small curly hair, and the flooring was dusty, stained, and appeared sticky. On 1/26/26 at 9:35 AM, Residents residing in room [ROOM NUMBER] (R64, R48, R59) were observed lying upon worn, ripped, stained, unclean fitted sheets. The bed frames were observed with dried substance matter along the perimeter of the mattresses. All three tube feeding pumps, poles, and bases were observed with dried splattered brown colored matter. The wall behind R59 was observed with a large opening exposing compromised dry wall. On 1/26/26 at 12:20 PM, the first-floor east shower room flooring was observed dirty, grimy, and small areas of dried white matter splattered on the floor in front of the sink. The toilet was observed having bowel movement and appeared to be sitting in the toilet bowl for some time. The shower bed mattress was unkempt and storing a soiled Hoyer lift tarp. The ceiling vent was observed with moderate dust coating the vents. The shower room on the first-floor west was observed with a grimy floor, and a pooled pile of water next to a black wheelchair which was observed covered in dirt, debris, and candy wrappers. A black seated cushion was observed lying next to the wheelchair with a large amount of brown colored dried substances. The room was cluttered with two Hoyer lifts (equipment to transfer and lift people), a ripped floor mat rolled up on the floor, two shower chairs with both seated areas ripped and exposing the foam padding. Oxygen tubing in a clear bag was observed on the floor underneath the shower chair along with a black comb. A Styrofoam cup with a lid was sitting on the sink counter and the toilet was covered in a clear plastic wrapping. The second-floor shower room west sink contained a moderate amount of pooled grey colored water revealing a ring around the perimeter of the basin indicating the water was sitting in basin for a while. The room was observed with a sewage type odor, and the shower bed padding was observed with tears (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2628775. Based on interview and record review, the facility failed to report allegations of staff to resident physical and sexual abuse and resident to resident abuse (poisoning) to the State Agency within the required time frame that included accurate information regarding the allegations, report to law enforcement, and submit a five-day investigation to the State Agency for two (R86 and R88) of two residents reviewed for abuse, resulting in a delay in investigation into allegations of R86 being poisoned by R18 and raped by a staff member, and R88 being held down by her wrists by staff. Findings include: On 1/26/26 at 2:00 PM, the Administrator was asked to provide R88's Facility Reported Incident (FRI) report for review. Review of the FRI documentation submitted by the facility to the State Agency on 8/13/25 at 2:59 PM, with an investigation submitted on 8/20/25 at 9:28 PM. The documentation report read, .Perpetrator Name [Name redacted] .Certified Nursing Assistant (CNA 'H').Were There Any Witnesses? No .Date/Time Incident Discovered: 8/13/2025 12:30 PM .Date/Time Incident Occurred: 8/12/2025 12:30 PM .Facility Investigator: (Director of Social Services/DSS 'T') .Incident Summary: CNA (HH) reported that another resident stated that she witnessed the C.N.A in her room caring for a her [sic] roommate [R88] for an for an [sic] extended amount of time . The report did not identify the specific allegation of mistreatment. Further review of the facility's investigation summary included: .On 8\12\2025 Risk Management Coordinator (DSS 'T') was informed of an alleged incident from a C.N.A (HH) that was reported to her through (R86), (R88s) roommate. R86 alleged that CNA 'H' appeared to be caring for the roommate for an extended period of time. (R86) was not able to confirm any inappropriate behavior other than (CNA 'H') normally spending 15 minutes at most but this time he was in the room for approximately 45 minutes. Interviews: (R86) was interviewed regarding concerns and she stated that she did not see (CNA 'H') do anything inappropriately. She was concerned about the time that he spent caring for her as it was longer than normal. (R88) - Unable to interview residents as she has a BIMS of 2 and not able to verbally communicate. Skin and Pain assessment completed immediately. No skin or pain concerns noted. (CNA 'HH') was interviewed to what was reported to her by (R86). (R86) reported to (CNA 'HH') that (CNA 'H') was on (R88) side for an extended period of time. (R86) stated that she waited for about 15 minutes and then went to the bathroom and seen (CNA 'H') holding (R88) arm close to her wrist. (R86) at that time began to yell at (CNA 'H') asking What are you doing. (R86) stated that (CNA 'H') stated I am caring for her. (Administrator) interviewed (R86) the following morning. (R86) stated to writer that (CNA 'H') was caring for (R88) longer than normal and that made her uncomfortable. When writer asked her if she had witnessed or heard anything and resident stated no. She only heard (R88) making noise during care but nothing out the ordinary. Writer asked (R86) has she had any concerns with her care from (CNA 'H') and she said no. She was just concerned because he was in the room longer than normal. (CNA 'H') was interviewed regarding the allegation. (CNA 'H') stated when he entered the room he noticed that (R88) removed her brief and had been playing in BM (bowel movement). He exited to room to gather supplies to clean her up and also grabbed the nurse to come in and witness her condition. He had to give her a bed bath, change her gown, linen, and also clipped and cleaned her nails as her nails were longer than normal and also had BM underneath them. (CNA 'H') does admit to being in the room longer than normal due to (R88) requiring more (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235293	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Farmington	34225 Grand River Ave Farmington, MI 48335

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance than normal. Interviewed all resident with BIMS of 11 and higher on (R86's) hallway to ensure they have had no concerns with staff during their stay. All residents interviewed has no concerns. Conclusion: The facility was unable to substantiate the allegations based on record review and interviews.(CNA 'H') has also been reassigned from the 1st floor to the 2nd floor. Center will continue to monitor resident per her plan of care. The facility respectfully requests a desk review. Action Plans: Notification of Physician Notification of Guardian Pain Assessment Completed: No Pain Noted Skin Assessment Completed: No Injury Noted Care Plans Reviewed. When (date and time) did the problem occur? 08/12/2025 12:30 PM Are law enforcement agencies involved? No Were There Any Witnesses? No Were Other Agencies Notified? No. There were no interviews included in the file initially provided by the facility. However, upon reviewing additional FRI's for R86 it was revealed the files were disorganized and additional documentation for this investigation was found filed within several other files, separate form this investigation. Further review of the additional documentation revealed, despite the FRI reporting the facility had first been discovered on 8/13/25 at 12:30 PM and the incident occurred on 8/12/25 at 12:30 PM, the following witness statements revealed this incident was initially identified by facility staff on 8/11/25 at 2:45 PM to (Former Director of Social Services/DSS 'U') and also identified a different date of when the allegation occurred. This documentation included the following statements: STATEMENT OF WITNESS documents read: .Name and Position of Witness: (Social Service Staff/SS 'V') .Date and time of incident: 8/10/25 10:00 PM .Resident Name: (R86) .Name and title of person conducting interview: (Former DSS 'U') .Date and place of interview: 8/11/25 2:45 PM . .Statement of Witness .Resident reports during night shift yesterday, she observed the CNA assisting her roommate excessively long. Resident reports she observed the CNA bent over roommate & holding her wrists down. Resident reports her roommate looked upset. Resident reported when she asked what the CNA was doing, he reported he was clipping her nails. It should be noted that the allegation of holding her wrists down was not included in any of the documentation provided to the State Agency, or within the facility's investigation summary. Another STATEMENT OF WITNESS document read: .Name and Position of Witness: (SS 'V') .Date and time of incident: 8/10/25 10:00 PM .Resident Name: (R88) .Name and title of person conducting interview: (Former DSS 'U') .Date and place of interview: 8/11/25 2:45 PM . (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Statement of Witness .Resident was rarely understood during interview, based on observation, resident seemed nervous & reluctant to speak. SW (Social Work) did not observe any physical symptoms/wounds. Residents nails were not clipped. Resident did smile at end of interview. It should be noted that this information was not identified by the facility's investigation, in which CNA 'H' reported they had clipped R88's fingernails. Another STATEMENT OF WITNESS document read: .Name and Position of Witness: (left blank) .Date and time of incident: (left blank) .Resident name: (R86) .Name and title of person conducting interview: (Business Office Manager/BOM 'GG') .Date and place of interview: 8/12/25 Admin Office . .Statement of Witness .When speaking to (R86) on the morning of 8-12-25 She stated that (CNA 'H') the CNA normally take 15 moments at the most to provide care to her or her roomate [sic]. So when (CNA 'H') was providing care to (another name for R88) it was alarming to her because of how long it was taking him to provide care to (R88) she also stated (R88) was making strange noises so she pulled the curtain back and seen (CNA 'H') shadow standing over (R88) and he did something with a towel and threw it on the floor. she then stated she got up and act as if she was going to the restroom so she can see what (CNA 'H') was doing so she observed him with his hands around (R88) wrist tight. she asked what was he doing so she observed him with his hands around (R88) wrist tight. She asked what was he doing to her and he said she has his arm and he was trying to get her to let go. After he got done providing care he went to (R86) to explain he would never hurt a resident. The section for signature and date for witness and interviewer was left blank. It should be noted that this information about CNA 'H's hand around R88's wrist tight or that CNA 'H' had further discussion with R88 about what they alleged was not included in the documentation submitted to the State Agency, or within the facility's investigation. The facility's investigation documented that a skin assessment had been completed immediately, however this documentation which was found in another FRI investigation for R86 revealed the skin assessment for R88 had been completed on 8/9/25 (prior to the incident and the next documented skin assessment wasn't until 8/19/25). On 1/28/26 at 11:10 AM, an interview was conducted with the Administrator in the presence of Vent Administrator, the Regional Director of Operations (RDO 'II' and RDO 'JJ') and later joined by Corporate Clinical Support (Nurse 'KK'). When queried about the inaccurate, unorganized and misleading documentation included within the facility's investigation for R88, the Administrator was unable to offer any further explanation. When asked about the limited documentation provided and documentation found in other investigations and general lack of organized, accurate documents, the Administrator reported they could not offer any further explanation. When queried about why R88's allegation of being held down by CNA 'H' was not included in the report made to the State Agency, why the police were not notified, and why the documentation was disorganized, and the investigation not reflective of the actual statements included in the witness statements, the Administrator reported the police should've been contacted and reported they went off what was told to them. When asked about the delay in reporting the allegation to the State Agency, the Administrator reported they were not able to offer any further explanation. Review of the clinical record revealed R88 was initially admitted into the facility on [DATE], and discharged on 11/11/25 with diagnoses that included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, altered mental (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status, aphasia, unspecified convulsions, metabolic encephalopathy, and aneurysm of unspecified site. According to the MDS assessment dated [DATE], R88 had severe cognitive impairment, had unclear speech and sometimes makes themselves understood, rarely/never understands others, and was dependent upon staff for most aspects of care. According to the facility's policy titled, Abuse, Neglect and Exploitation dated 1/10/2024: .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and .Providing complete and thorough documentation of the investigation .Reporting/Response .Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes as required by state and federal regulations: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or 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 . R86 On 1/28/26 at 8:23 AM, the Administrator was asked to provide any incident reports and investigations for R86 for the month of August 2025. Multiple investigation files were provided and reviewed. Incident #1 (R86 and Certified Nursing Assistant – CNA 'H') A review of a FRI (Facilty Reported Incident) report submitted by the facility to the State Agency revealed on 8/18/25, R86 Reported an allegation of abuse against (CNA 'H') .Nurse Aide was suspended pending investigation. The report did not include what the abuse allegation was specifically. A review of the investigation file provided by the facility regarding that allegation on 8/18/25 revealed an incident report completed by Licensed Practical Nurse (LPN) 'D' on 8/18/25 that noted, .Pt (patient) reported alleged abuse to administrator.Pt states Nurse assistant raped her while doing patient care. It was documented the Director of Nursing (DON) was notified on 8/18/25 at 12:00 PM and the Administrator was notified on 8/19/25 at 4:29 PM. A review of the Investigation Summary completed by the Administrator revealed the following documentation, .On August 18th (R86) contacted the Abuse Coordinator to report that on August 11th, 2025, she felt that during her sleep she feels as if someone entered her room and did something to her. She stated that person is (CNA 'H') . There was nothing documented in the investigation summary submitted to the State Agency that mentioned the allegation of rape made by R86 as documented on the incident report. There was no indication that law enforcement was contacted regarding the allegation of rape made by R86. Incident #2 (R86 and R18) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an investigation conducted by the facility revealed on 8/23/25, R86 texted the Abuse Coordinator (who was the Administrator) and alleged R18 poisoned her coffee. It was documented the incident occurred on 8/23/25 at 7:30 AM and it was discovered at 8:00 AM. It was documented on the Facility Reported Incident (FRI) report that the allegation was submitted to the State Agency on 8/23/25 at 8:00 PM, 12 hours after the allegation was made (discovered). Further review of the FRI report and the investigation folder provided by the facility revealed no investigation was submitted to the State Agency within the five-day required time frame. Incident #3 (R86 and LPN 'D') A review of an investigation conducted by the facility revealed on 8/26/26, R86 alleged LPN 'D' poisoned her and the resident contacted 911 to be transferred to the hospital. It was documented the incident occurred on 8/26/25 at 2:00 PM and it was discovered on 8/26/25 at 4:00 PM. According to the FRI report, the allegation was submitted to the State Agency on 8/27/25 at 2:15 PM, 22 hours after the allegation was made. On 1/28/26 at 10:48 AM, an interview was attempted with LPN 'D' via the telephone. LPN 'D' was not available for interview prior to the end of the survey. On 1/28/26 at 11:00 AM, an interview was conducted with the Administrator (Abuse Coordinator). When queried about the facility's protocol when a resident alleged abuse, the Administrator reported staff were to contact her immediately and that her phone number is accessible in the facility. Once she was contacted, she initiated an investigation into the allegation, and all allegations were reported to the State Agency within two hours. When queried about what would be reported to law enforcement, the Administrator reported any abuse was reported. When queried about why R86's allegation of rape by a staff member was not included in the report made to the State Agency, the Administrator reported R86 did not allege rape when she contacted her. When asked why the allegation of rape was not included in the investigation summary or why it was not reported once she was made aware, the Administrator did not offer a response. When queried about whether the sexual abuse allegation was reported to law enforcement, the Administrator reported it was not. When queried about why there was no investigation submitted within five days to the State Agency regarding R86's allegation of being poisoned by R18, the Administrator reported she did not know why and confirmed an investigation was not completed. When queried about why the allegation that R18 poisoned R86 was not reported to the State Agency until 12 hours after the allegation was made and the allegation that LPN 'D' poisoned R86 was not reported to the State Agency until 22 hours later, the Administrator did not offer a response. A review of R86's clinical record revealed R86 was admitted into the facility on 5/9/25 and discharged on 8/28/25 with diagnoses that included: schizoaffective disorder. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R86 had intact cognition.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake(s): #2628775 and #2607040. Based on interview and record review, the facility failed to complete thorough investigations of allegations of staff to resident physical and sexual abuse and allegations of poisoning by R18 and a staff member and failed to implement interventions to protect the residents during the investigations for two (R86 and R88) of two resident reviewed for abuse. Findings include: On 1/26/26 at 2:00 PM, the Administrator was asked to provide R88's FRI report for review. Review of the FRI documentation submitted by the facility to the State Agency on 8/13/25 at 2:59 PM, with an investigation submitted on 8/20/25 at 9:28 PM. The documentation report read, .Perpetrator Name [Name redacted] .Certified Nursing Assistant (CNA 'H').Were There Any Witnesses? No .Date/Time Incident Discovered: 8/13/2025 12:30 PM .Date/Time Incident Occurred: 8/12/2025 12:30 PM .Facility Investigator: (Director of Social Services/DSS 'T') .Incident Summary: CNA (HH) reported that another resident stated that she witnessed the C.N.A in her room caring for a her [sic] roommate [R88] for an for an [sic] extended amount of time . The report did not identify the specific allegation of mistreatment. Further review of the facility's investigation summary included: .On 8\12\2025 Risk Management Coordinator (DSS 'T') was informed of an alleged incident from a C.N.A (HH) that was reported to her through (R86), (R88s) roommate. R86 alleged that CNA 'H' appeared to be caring for the roommate for an extended period of time. (R86) was not able to confirm any inappropriate behavior other than (CNA 'H') normally spending 15 minutes at most but this time he was in the room for approximately 45 minutes. Interviews: (R86) was interviewed regarding concerns and she stated that she did not see (CNA 'H') do anything inappropriately. She was concerned about the time that he spent caring for her as it was longer than normal. (R88) - Unable to interview residents as she has a BIMS (brief interview for mental status) of 2 and not able to verbally communicate. Skin and Pain assessment completed immediately. No skin or pain concerns noted. (CNA 'HH') was interviewed to what was reported to her by (R86). (R86) reported to (CNA 'HH') that (CNA 'H') was on (R88) side for an extended period of time. (R86) stated that she waited for about 15 minutes and then went to the bathroom and seen (CNA 'H') holding (R88) arm close to her wrist. (R86) at that time began to yell at (CNA 'H') asking What are you doing. (R86) stated that (CNA 'H') stated I am caring for her. (Administrator) interviewed (R86) the following morning. (R86) stated to writer that (CNA 'H') was caring for (R88) longer than normal and that made her uncomfortable. When writer asked her if she had witnessed or heard anything and resident stated no. She only heard (R88) making noise during care but nothing out the ordinary. Writer asked (R86) has she had any concerns with her care from (CNA 'H') and she said no. She was just concerned because he was in the room longer than normal. (CNA 'H') was interviewed regarding the allegation. (CNA 'H') stated when he entered the room he noticed that (R88) removed her brief and had been playing in BM (bowel movement). He exited to room to gather supplies to clean her up and also grabbed the nurse to come in and witness her condition. He had to give her a bed bath, change her gown, linen, and also clipped and cleaned her nails as her nails were longer than normal and also had BM underneath them. (CNA 'H') does admit to being in the room longer than normal due to (R88) requiring more assistance than normal. Interviewed all resident with BIMS of 11 and higher on (R86's) hallway to ensure they have had no concerns with staff during their stay. All residents interviewed has no concerns. Conclusion: The facility was unable to substantiate the allegations based on record review and interviews.(CNA 'H') has also been reassigned from the 1st floor (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the 2nd floor. Center will continue to monitor resident per her plan of care. The facility respectfully requests a desk review. Action Plans: Notification of Physician Notification of Guardian Pain Assessment Completed: No Pain Noted Skin Assessment Completed: No Injury Noted Care Plans Reviewed. When (date and time) did the problem occur? 08/12/2025 12:30 PM Are law enforcement agencies involved? No Were There Any Witnesses? No Were Other Agencies Notified? No. There were no interviews included in the file initially provided by the facility. However, upon reviewing additional FRI's for R86 it was revealed the files were disorganized and additional documentation for this investigation was found filed within several other files, separate form this investigation. Further review of the additional documentation revealed, the incident was reported to facility staff and documented on a witness statement on 8/11/25 that the alleged incident occurred on 8/10/25. However the facility's documentation submitted to the State Agency documented the alleged incident had first been discovered on 8/13/25 at 12:30 PM and the incident occurred on 8/12/25 at 12:30 PM. The following witness statements revealed this incident was initially identified by facility staff on 8/11/25 at 2:45 PM to (Former Director of Social Services/DSS 'U') and also identified a different date of when the allegation occurred. This documentation included the following statements: STATEMENT OF WITNESS documents read: .Name and Position of Witness: (Social Service Staff/SS 'V') .Date and time of incident: 8/10/25 10:00 PM .Resident Name: (R86) .Name and title of person conducting interview: (Former DSS 'U') .Date and place of interview: 8/11/25 2:45 PM . .Statement of Witness .Resident reports during night shift yesterday, she observed the CNA assisting her roommate excessively long. Resident reports she observed the CNA bent over roommate & holding her wrists down. Resident reports her roommate looked upset. Resident reported when she asked what the CNA was doing, he reported he was clipping her nails. The allegation of holding her wrists down was not included in any of the documentation provided to the State Agency, or within the facility's investigation summary. Another STATEMENT OF WITNESS document read: .Name and Position of Witness: (SS 'V') .Date and time of incident: 8/10/25 10:00 PM .Resident Name: (R88) .Name and title of person conducting interview: (Former DSS 'U') .Date and place of interview: 8/11/25 2:45 PM . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Statement of Witness .Resident was rarely understood during interview, based on observation, resident seemed nervous & reluctant to speak. SW (Social Work) did not observe any physical symptoms/wounds. Residents nails were not clipped. Resident did smile at end of interview. This information was not identified by the facility's investigation, in which CNA 'H' reported they had clipped R88's fingernails. Another STATEMENT OF WITNESS document read: .Name and Position of Witness: (left blank) .Date and time of incident: (left blank) .Resident name: (R86) .Name and title of person conducting interview: (Business Office Manager/BOM 'GG') .Date and place of interview: 8/12/25 Admin Office . .Statement of Witness .When speaking to (R86) on the morning of 8-12-25 She stated that (CNA 'H') the CNA normally take 15 moments at the most to provide care to her or her roomate [sic]. So when (CNA 'H') was providing care to (another name for R88) it was alarming to her because of how long it was taking him to provide care to (R88) she also stated (R88) was making strange noises so she pulled the curtain back and seen (CNA 'H')'s shadow standing over (R88) and he did something with a towel and threw it on the floor. she then stated she got up and act as if she was going to the restroom so she can see what (CNA 'H') was doing so she observed him with his hands around (R88) wrist tight. she asked what was he doing so she observed him with his hands around (R88) wrist tight. She asked what was he doing to her and he said she has his arm and he was trying to get her to let go. After he got done providing care he went to (R86) to explain he would never hurt a resident. The section for signature and date for witness and interviewer was left blank. The information about CNA 'H's wrist around R88's wrist tight or that CNA 'H' had further discussion with R88 about what they alleged was not included in the documentation submitted to the State Agency, or within the facility's investigation. The facility's investigation documented that a skin assessment had been completed immediately, however this documentation which was found in another FRI investigation for R86 revealed the skin assessment for R88 had been completed on 8/9/25 (prior to the incident and the next documented skin assessment wasn't until 8/19/25). Further review of the time punch details for CNA 'H' revealed the employee continued to work the midnight shift on 8/12 and 8/14/25. The Administrator was requested to provide dates of CNA 'H's suspension and provided a handwritten note that stated 8/16/25 – 8/26/25. CNA 'H' had not been suspended pending investigation when the initial allegation was identified on 8/11/25. On 1/28/26 at 11:10 AM, an interview was conducted with the Administrator in the presence of Vent Administrator, the Regional Director of Operations (RDO 'II' and RDO 'JJ') and later joined by Corporate Clinical Support (Nurse 'KK'). When queried about the inaccurate, unorganized and misleading documentation included within the facility's investigation for R88, the Administrator was unable to offer any further explanation. When asked about the limited documentation provided and documentation found in other investigations and general lack of organized, accurate documents, the Administrator reported they could not offer any further explanation. When queried about why R88's allegation of being held down by CNA 'H' was not included in the report made to the State Agency, why the police were not notified, why the CNA wasn't suspended, and why the documentation was disorganized, and the investigation not reflective of the actual statements included in the witness statements, the Administrator reported the police should've been contacted and reported they went off what was told to them. When asked about the delay in reporting the allegation to the State Agency, the Administrator (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported they were not able to offer any further explanation. Review of the clinical record revealed R88 was initially admitted into the facility on [DATE], and discharged on 11/11/25 with diagnoses that included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, altered mental status, aphasia, unspecified convulsions, metabolic encephalopathy, and aneurysm of unspecified site. According to the MDS assessment dated [DATE], R88 had severe cognitive impairment, had unclear speech and sometimes makes themselves understood, rarely/never understands others, and was dependent upon staff for most aspects of care. According to the facility's policy titled, Abuse, Neglect and Exploitation dated 1/10/2024: .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and .Providing complete and thorough documentation of the investigation .Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. B. Examing the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. C. Increased supervision of the alleged victim and residents. D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. E. Protect from retaliation. R86 On 1/28/26 at 8:23 AM, the Administrator was asked to provide any incident reports and investigations for R86 for the month of August 2025. Multiple investigation files were provided and reviewed. Incident #1 (R86 and Certified Nursing Assistant – CNA 'H') A review of a FRI report submitted by the facility to the State Agency revealed on 8/18/25, R86 Reported an allegation of abuse against (CNA 'H') .Nurse Aide was suspended pending investigation. The report did not include what the abuse allegation was specifically. A review of the investigation file provided by the facility regarding that allegation on 8/18/25 revealed an incident report completed by Licensed Practical Nurse (LPN) 'D' on 8/18/25 that noted, .Pt (patient) reported alleged abuse to administrator.Pt states Nurse assistant raped her while doing patient care. It was documented the Director of Nursing (DON) was notified on 8/18/25 at 12:00 PM and the Administrator was notified on 8/19/25 at 4:29 PM. A review of the Investigation Summary completed by the Administrator revealed the following documentation, .On August 18th (R86) contacted the Abuse Coordinator to report that on August 11th, 2025, she felt that during her sleep she feels as if someone entered her room and did something to her. She stated that person is (CNA 'H') . It was documented CNA 'H' was suspended pending the investigation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 8/18/25. There was nothing documented in the investigation summary submitted to the State Agency that mentioned the allegation of rape made by R86 as documented on the incident report. Incident #2 (R86 and R18) A review of an investigation conducted by the facility revealed on 8/23/25, R86 texted the Abuse Coordinator (who was the Administrator) and alleged R18 poisoned her coffee. It was documented the incident occurred on 8/23/25 at 7:30 AM and it was discovered at 8:00 AM. It was documented on the Facility Reported Incident (FRI) report that the allegation was submitted to the State Agency on 8/23/25 at 8:00 PM, 12 hours after the allegation was made (discovered). Further review of the FRI report and the investigation folder provided by the facility revealed no investigation was submitted to the State Agency within the five-day required time frame. Incident #3 (R86 and LPN 'D') A review of an investigation conducted by the facility revealed on 8/19/26, R86 alleged LPN 'D' contacted the police and alleged LPN 'D' poisoned her coffee. A review of the facility's investigation summary revealed, .On August 19th at roughly 815pm, (R86) contacted the police and wanted to be transferred to the hospital. (R86) alleged to the local police that her nurse (LPN 'D') poisoned her coffee. The police arrived and escorted (R86) to the hospital at roughly 845pm.NHA (Nursing Home Administrator) requested lab work and urinalysis to be performed on her return from the hospital. Hospital paperwork, lab results and facility lab results pulled for review. Interviewed (LPN 'D'). (LPN 'D') stated that she did not have any involvement with preparing or delivering any coffee to (R86). Interviewed (R86's roommate) to see if she had any concerns with her food or if she felt ok. She did not witness anything. Also asked if she witnessed anyone put anything in (R86's) water when it was delivered. She stated no. (Unit Manager, Registered Nurse – RN 'K') reviewed the surveillance video to determine if any suspicious activities were noted during the water pass. Unit Manager did not see anything abnormal during the video.The facility was unable to substantiate the allegations based on record review and interviews. There was no evidence that R86 was interviewed regarding her allegation. Incident #4 (R86 and LPN 'D') A review of an investigation conducted by the facility revealed on 8/26/26, R86 alleged LPN 'D' poisoned her, and the resident contacted 911 to be transferred to the hospital. It was documented the incident occurred on 8/26/25 at 2:00 PM and it was discovered on 8/26/25 at 4:00 PM. A review of the facility's investigation summary revealed interviews with LPN 'D' and R86's roommate which were the same interview from the allegations made on 8/19/25 regarding LPN 'D' allegedly poisoning R86's coffee. The allegation made on 8/26/25 did not say R86's coffee was poisoned, only that she was poisoned. There was no evidence R86 was interviewed regarding the allegations and no evidence of any further investigation into how or what R86 believed she was poisoned with. On 1/28/26 at 11:00 AM, an interview was conducted with the Administrator (Abuse Coordinator). When asked why the allegation of rape was not included in the investigation summary the Administrator did not offer a response. When queried about why there was no investigation completed regarding R86's allegation of being poisoned by R18, the Administrator reported she did not know why and confirmed an investigation was not completed. When queried about why the investigation into R86's allegation of being poisoned by LPN 'D' on 8/26/25 was the same as the investigation into R86's allegation of LPN 'D poisoning her coffee on 8/19/25, the Administrator reported she submitted the wrong (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	investigation. At that time, the correct investigation was requested. When queried about why R86 was not further interviewed to get additional information about her allegations, the Administrator reported she was. When queried about why the content of those interviews were not included in the investigations, the Administrator did not offer a response. No additional information was provided prior to the end of the survey. On 1/28/26 at 1:09 PM, a review of LPN 'D' personnel files was conducted. There was no evidence that LPN 'D' was suspended pending the investigations into the allegations on 8/18/25 and 8/26/25 that she poisoned R86. On 1/28/26 at approximately 2:00 PM, an interview was conducted with the Administrator. When queried about whether LPN 'D' was suspended pending the investigations after it was alleged on 8/18/25 and 8/26/25 that she poisoned R86, the Administrator reported she was not suspended and did not offer an explanation why. A review of R86's clinical record revealed R86 was admitted into the facility on 5/9/25 and discharged on 8/28/25 with diagnoses that included: schizoaffective disorder. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R86 had intact cognition.

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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. This citation pertains to intake #'s 2629174 and 2639760. Based on observation, interview, and record review, the facility failed to ensure ongoing assessment and accurate treatment orders for wound care for one resident (R22) of one resident reviewed for wound care, resulting in verbalized complaints with quality of care and the potential for wound complications. Findings include: On 1/27/26 at 11:02 AM, a phone call was placed to the complainant, and they expressed concerns over a new wound R22 developed to their left thigh/buttock area and did not think the facility was properly addressing the wound. On 1/27/26 at 12:16 PM, an observation of R22's wound was conducted with Nurse 'A'. Nurse 'A' peeled back the foam dressing, and the wound was observed to be a skin tear approximately 3 cm (centimeters) in length in the skin fold of their left gluteal sulcus (the spot where the thigh meets the buttock). At that time Nurse 'A' was asked about R22's treatment order and said the treatment was triple antibiotic ointment on the wound and cover with a foam dressing. On 1/27/26 at 12:28 PM, a review of R22's progress notes was conducted and revealed a note dated 1/4/26 at 3:03 PM that read, Was brought to writers [sic] attention that patient had a new area on her right leg under her buttock, in the crease . R22's weekly wound assessments were reviewed and the assessments performed on 1/7/26, 1/8/26, 1/15/26, and 1/22/26 did not document the presence of the wound on R22's right or left buttock/thigh area. It was noted the first documented assessment of the wound was dated 1/27/26. A review of R22's orders revealed an order dated 1/4/26 for a treatment to the right gluteal fold and an order to consult wound care with, No directions specified for order. On 1/27/25 at 12:40 PM, R22's record revealed a new wound care order entered by Wound Care Nurse 'PP' scheduled to start on 1/28/26 that read, Wound care: Rear Right Thigh; Cleanse area with normal saline, pat dry, apply triple antibiotics [sic] ointment, cover with border foam one time a day for wound care.On 1/27/26 at 1:39 PM, an interview was conducted with Wound Care Nurse 'PP'. They were asked why R22's wound was identified on 1/4/26 but no assessments of the wound were documented. Nurse 'PP' said the nursing staff had not made them aware of the new wound until earlier in the morning on 1/27/26. They were then asked to identify the gluteal side (right or left) the wound affected and they reported it was on their left gluteal. At that time, it was brought to their attention that all orders for the treatment since 1/4/26 indicated the wound was on the right gluteal cleft including their new order for the treatment starting on 1/28/26. Nurse 'PP' admitted the mistake and said they would change the order. A request for a policy for wound care was made, however; the policy provided only addressed wound care for pressure ulcers. The policy titled, Pressure Ulcer/Skin Breakdown-Clinical Protocol revised 3/2024 was reviewed and read, 5 .all PU/PI (pressure ulcers/pressure injury) or other skin related issues are measured and documented .7. continued assessment and management .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake(s): #2610189 and #2658977 Based on observation, interview, and record review, the facility failed to administer tube feeding according to physician's orders for one (R79) of five residents reviewed for tube feeding. Findings include:On 1/26/26 at 10:22 AM, R79 was observed lying in bed, sleeping. R79 was receiving breathing assistance via a mechanical ventilator. R79 had a Percutaneous Endoscopic Gastrostomy (PEG) tube which delivered nutrition directly into R79's stomach. A tube feeding pump was observed in R79's room and was hooked up to the resident. A bottle of tube feeding formula was hung and dated 1/25/26. 850 milliliters (ml) of formula remained in the bottle. The tube feeding pump was not running at that time and an error message was present on the screen that read, Pump inactive. Pump has been idle for 10 minutes. On 1/26/26 at 11:45 AM, R79's tube feeding pump remained with the same error message that it was inactive. 850 ml remained in the bottle. On 1/26/26 at 2:10 PM, R79's tube feeding pump was alarming with a beeping sound. The screen read, Tube slip detected. Remove and reload cassette. 850 ml of formula remained in the bottle. On 1/26/26 at 3:49 PM, R79's tube feeding pump continued to alarm with a beeping sound and the same error remained on the screen, Tube slip detected. Remove and reload cassette. 850 ml of formula remained in the bottle. At that time Respiratory Therapist (RT) 'MM' entered the room to provide respiratory care and R79's husband was present in the room. After RT 'MM' exited the room, she was observed seated in the hallway. R79's tube feeding pump remained alarming. At that time, R79's husband said he was not sure why the pump was alarming and it had been doing that all day. R79's husband said he was not sure why a nurse has not addressed it. On 1/26/26 at approximately 3:52 PM, an interview was conducted with RT 'MM'. When queried about whether she reported the alarming tube feeding pump to the nurse. RT 'MM' said she did not notice it was alarming and reported she was new and did not alert anyone. On 1/26/26 at approximately 3:55 PM, an interview was conducted with Registered Nurse (RN) 'J'. RN 'J' reported he was not R79's assigned nurse that day, but her assigned nurse was on break. When queried about what should be done if a tube feeding pump has an error or was alarming, RN 'J' said a nurse was supposed to be alerted so it could be looked at and restarted. At that time RN 'J' observed R79's tube feeing pump and said a nurse should have been notified. On 1/26/26 at approximately 4:00 PM, an interview was conducted with the Director of Nursing (DON) who reported nursing should be made aware of any alarm or error message on a tube feeding pump so it could be reset. The DON reported anyone who noticed it was responsible to report to the nurse. A review of R79's physician's orders revealed no active orders to hold the tube feeding. R79 had an active order for Enteral Feed Order every shift every day and night shift Nepro with CARBSTEADY via peg @ 50ml/hr (milliliters per hour) x 20hrs (hours) to provide 1800kcals (kilocalories), 75g (grams) protein, 1000mls free water daily. A review of R79's clinical record revealed R79 was admitted into the facility on 9/15/25 and readmitted on [DATE] with diagnoses that included: chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, congestive heart failure, and dysphagia. R79 required a mechanical ventilator to assist with breathing and had a PEG tube to deliver all nutrition. R70 did not consume any food by mouth. A review of R79's Minimum Data Set (MDS) assessment dated [DATE] revealed R79 had moderately impaired cognition and was dependent on staff for all activities of daily living. A review of a facility policy titled, Feeding Tubes revised 10/15/24, revealed, in part, the following, .Feeding tubes will be utilized according to physician orders.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. This citation pertains to Intake(s): #2629174, #2639760, #2658977, #2702355, and #2608297. Based on observation, interview, and record review, the facility failed to ensure there was sufficient nursing staff to meet the needs of the residents, resulting in a three hour delay in incontinence care for R16, R9, R43, R67, R71 and eight residents who wished to remain anonymous who attended the resident council interview and had the potential to affect all 83 residents who resided in the facility. Findings include: A review of a PBJ (Payroll Based Journal) Staffing Data Report for Fiscal Year (FY) Quarter 4 (7/1/25 – 9/30/25) revealed the facility triggered for excessively low weekend staffing based on the data they submitted. On 1/26/26 at 9:28 AM, R16 was observed sitting up in bed. R16 was able to understand questions asked and mouth answers but was unable to speak due to being dependent on a mechanical ventilator to breathe. R16's family member was at his bedside. An interview was conducted with R16 and his family member at that time. R16 reported he pushed the call light the night before at 4:00 AM and nobody helped him until 7:00 AM. R16 reported he needed his incontinence brief changed. When asked if anyone came into his room during that time, R16 said staff came in two times, but did not provide the care. R16's family member reported they did not think there was enough staff to care for the residents' needs during the weekends. On 1/26/26 at approximately 9:32 AM, R43 and R71 were observed lying in bed. Both residents were alert and able to answer questions asked. When asked about care at the facility, R71 reported that they are always low on staffing. Both R43 and R71 reported that on the midnight shift Sunday (1/25-1/26/26) there was only one CNA (certified nursing assistant) on the first floor from 2:00 AM to 7:00 AM. They stated it impeded on their roommate who requested to get out of bed by 6/6:30 AM as scheduled. R71 also reported that there were two residents that resided on the same hallway that kept screaming at one another and it appeared as if no staff could get them to calm down. On 1/26/26 at approximately 10:26 AM, CNA N was asked about staffing. They reported that there were only two CNA's working on the first floor today (1/26/26) as one CNA had called in. 33 residents resided on the first floor on 1/26/26. On 1/26/26 at approximately 10:30 AM, R9 was observed lying in bed. A hospice CNA was in the room with the resident. When asked about staffing care in the building, R9 reported that they did not believe there was enough staff to always care for her as she needed two people to assist. They noted that one of the reasons they chose Hospice services was that it ensured that they received more staffing for help with care as the facility was always short-staffed. On 1/27/26 at 1:30 PM, a confidential resident council meeting was held with 12 residents. When asked about whether they felt there was adequate staffing to meet their needs, eight residents expressed they felt there was not enough staff. Their responses were as follows: Over the weekend there were none here. On Sunday no one was here. A manager finally came in the afternoon. The weekends are the worst. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A lot of staff recognizes the call light is on but will pass it up. Will keep on going down hall. End up waiting over an hour. It makes you feel insignificant. On 1/28/26 at approximately 9:11 AM, a nursing staff interview was conducted. The Nurse asked to remain anonymous. When asked about staffing they reported they did not feel like they could provide an honest answer as nursing staff are always yelled at when they report short staffing to State Surveyors. On 1/28/26 at approximately 10:15 AM, R67 was observed lying in bed. Their bedside table was out of reach from the resident. R67, who had difficulty verbally communicating, kept pointing to the table and tried to write on a piece of paper they needed assistance. R67 pressed their call light. CNA R entered the room and let R67 know that they know they moved the tray away from them as they were getting ready to give a shower but then had to leave to help other residents and left the tray table away from them. CNA R reported that they were assigned 17 residents and it was difficult to help residents timely. On 01/28/2026 at approximately 1:52 p.m., CNA I was queried regarding weekend staffing levels on Sunday evening (1/25/26) into the midnight shift. CNA I reported they were the only CNA for the ventilator unit on the second floor. CNA I indicated that if they were helping a resident and other call light buttons were going off with requests for assistance, they were unable to get to them on time. CNA I reported that over the last few months they worked by themselves about 19 times during their shifts. CNA I was asked how being short staffed affected the residents and they reported the residents had to wait longer for them to assist them. On 1/28/26 at approximately 2:25 p.m., Nurse SS was interviewed pertaining to staffing levels in the facility and they indicated that on Sunday midnight shift (1/25/26-1/26/26) the facility only had one (CNA) from 2:00AM-7:00AM on the first floor. Nurse SS indicated that many call lights were being pushed and there was not enough staff to answer all of them on time. On 1/28/26 at 12:07 PM, an interview was conducted with the Director of Nursing (DON) who was also in charge of the nursing staff scheduling in the absence of a Staffing Coordinator. When queried about how staffing was determined to meet the needs of the residents, the DON reported they followed the PPD (Nursing Hours per Patient Day) and operated within those numbers which were based on the census and time of day. When queried about how it was handled when staff called off of work, the DON reported they called people in to fill in the holes and if nobody was available, managers came in to work the floor. When queried about any staffing challenges on Sunday, 1/25/26-1/26/26, night shift, the DON reported she was unaware of any staffing problems that night. A review of the nursing staff schedule and assignment sheet and time punches from 1/25/26 night shift revealed CNA 'I' and CNA 'TT' punched out at 2:30 AM which left one CNA (CNA 'E') on the ventilator unit and one CNA (CNA 'G') on the First Floor. On 1/28/26 at 2:30 PM, a second interview was conducted with the DON and the above information regarding staffing on 1/25/26 night shift was discussed. The DON reported she was unaware that the facility was short staffed and said herself and the on call manager were not notified. *

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. This citation pertains to intake 2610189.Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent. Three medication errors were observed (R72, R9) from a total of 32 opportunities resulting in an error rate of nine percent.Findings include:A complaint was received by the State Agency on 9/7/25 alleging a resident was given the wrong medication.On 1/27/26 at 8:08 AM, Licensed Practical Nurse (LPN) A was observed for medication administration. R72 was ordered Metoprolol (medication to treat high blood pressure) Extended Release (ER) 25 milligrams (mg) to be given by mouth and instructions to do not crush. LPN A was observed crushing the medication mixed with water and administered via a Percutaneous Endoscopic Gastrostomy (PEG) tube (tube surgically inserted into the stomach to deliver nutrition, medication).On 1/28/26 at 8:35 AM, LPN B was observed for medication administration. R9 was ordered Miralax (medication to treat irregular bowel movements and constipation)17 grams. LPN B was observed pouring the medication granules into the measuring cap and poured only half the medication. LPN B was asked how they knew that was measured at 17 grams. LPN B replied this was explained to them before by another nurse and to fill the granules up to the inside threading of the cap. LPN B further remarked the last time they filled the entire white inside of the cap, it was too much. When inquired why it was too much LPN B said another resident had a blowout.On 1/28/26 at approximately 9:00 AM, an interview with Unit Manager (UM) Registered Nurse (RN) K was asked if they could demonstrate how nurses measure Miralax. UM RN K was observed retrieving the same Miralax bottle from LPN B and pointed on the cap to the stamped measuring line that read 17 grams. This measurement was the entire white portion of the cup, up to the purple part of cap. When shown where LPN B measured the Miralax earlier, UM RN K acknowledged this was not the entire ordered 17-gram dose of the medication and confirmed LPN B did not administer the entire dose of Miralax.On 1/28/26 at 12:08 the Director of Nursing (DON) was interviewed and acknowledged the above observations were medication errors and provided an opportunity for re-education.Review of the policy titled Medication Administration revised 1/17/2023 documented: .Medications are administered.in accordance with professional standards of practice.Compare medication source with MAR (medication administration record) to verify medication name, form, dose, route.Do not crush medications with do not crush instructions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to lock medication/treatment cart and failed to store medications safely and securely on the second floor. Findings include:On 1/27/26 at 9:58 AM, an observation of medication cart #3 on the second floor was conducted with Nurse 'OO'. During the observation the third large drawer on the left side of the medication cart was observed to contain an opened can of energy drink. Nurse 'OO' said it did not belong to them, and the previous nurse must have left it in there. Continued review of the cart revealed a box of Dulcolax suppositories with an expiration date of 11/2025, and a bottle of redness relieving eye drops in an opened box that did not contain a label for whom they belonged. Nurse 'OO' said expired medications should be discarded and all medications in the cart should be labelled with a patient name. On 1/26/26 at 10:35 AM, the second-floor respiratory cart was observed unlocked and not under direct observation of authorized staff. A second respiratory cart was observed unlocked and not under direct observation of authorized staff and had a key with an orange-colored key ring in the lock. Access to all drawers was observed and medications identified. On 1/26/26 at 10:43 AM, Respiratory Therapist (RT) MM was observed exiting a resident room, not in view of the cart, walked to the cart then proceeded to remove the keys. On 1/26/26 at 10:51 AM, RT MM was interviewed and confirmed by opening the drawers and showing respiratory cart drawers contained breathing supplies, equipment, and medication. On 1/27/26 at 8:13 AM, a treatment cart located on the second floor outside of room [ROOM NUMBER] was observed unlocked and not under direct observation of authorized staff. While making note of the observation, Unit Manger Register Nurse Y inquired if I was done going through the cart and proceeded to reach around and lock the cart. On 1/27/26 at 9:18 AM, Licensed Practical Nurse (LPN) A was observed for medication administration and when retrieving medication from the narcotic box of the second-floor medication cart, two clear medicine cups with a cloudy gel-like substance was observed lying sideways in-between narcotic blister packs. LPN A indicated these were for one of their residents to be administered. When asked where it came from, LPN A indicated they retrieved the medication from the treatment cart down the hall, put the ointment in the cups, and stored it in the narcotic box. When asked what the medication was, LPN A said they weren't sure what the medication was called, mentioned it was something for the residents' legs, and observed looking into the Medication Administration Record (MAR) to find the name. On 1/28/26 at 12:08PM, The Director of Nursing (DON) was interviewed and acknowledged all respiratory, medication and treatment carts need to be locked and storing of medication cup was unsanitary, and medication without patient identifier or medication labeling is not acceptable. Review of the Medication Storage Policy dated 1/2024 documented. .It is the policy of this facility to ensure all medications housed on our premises will be stored.to ensure proper sanitation.and security.

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	235293	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Farmington	34225 Grand River Ave Farmington, MI 48335

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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 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. This citation pertains to intake 2628775. Based on observation, interview, and record review, the facility failed to identify and implement effective plans of action to correct identified quality deficiencies related to system failures including implementation of their abuse policy. This had the potential to affect all residents (including R88) who resided in the facility. Findings include:According to the facility's policy titled, Abuse, Neglect and Exploitation dated 1/10/2024: .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and .Providing complete and thorough documentation of the investigation .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation .Reporting/Response .Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes as required by state and federal regulations: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or 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 .Coordination with QAPI .Cases of physical or sexual abuse, for example by facility staff or other residents, will be reviewed for and receive corrective action and tracking by the QAA Committee. This coordinated effort results in the QAA Committee determining: a. If a thorough investigation is conducted. b. Whether the resident is protected. c. Whether an analysis was conducted as to why the situation occurred. d. Risk factors that contributed to the abuse .and e. Whether there is further need for systemic action . On 1/28/26 at 11:00 AM, an interview was conducted with the Administrator, Vent Administrator and two Regional Director of Operations staff.At that time, R88's facility reported incident (FRI) involving R88 and an alleged perpetrator (Certified Nursing Assistant/CNA ‘H’) was reviewed. Concerns were identified with the facility's documentation of investigation into this incident which included lack of timely notification to the State Agency, lack of police report filed, lack of suspension of the alleged perpetrator pending investigation, and lack of a complete, thorough investigation into the allegation.When asked if R88's investigation had been reviewed with the QAA (Quality Assessment and Assurance) Committee to review for areas of deficiencies or that needed corrective action, the Administrator reported their process was to review abuse allegations as part of QAA which included R88's allegation and they did not identify any concerns.

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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. This citation pertains to intake #'s 2629174 and 2699963. Based on observation, interview, and record review, the facility failed to ensure an ongoing, comprehensive infection control program that: demonstrated ongoing facility surveillance for infections, identified infections and their origins, consistently utilized laboratory and diagnostic data, documented signs and symptoms of infections for monitoring for appropriate antibiotic usage, calculated facility infection rates, performed ongoing environmental surveillance, provided ongoing staff education, and adhered to accepted infection control principles such as hand hygiene and the use of proper transmission based precautions, resulting in the potential for the spread of infection, unidentified clusters or outbreaks of infection and inappropriate antibiotic usage. This deficient practice had the potential to affect all 83 residents who reside in the building. Findings include: On 1/28/26 at 11:04 AM, a review of the facility's comprehensive, ongoing infection control program was conducted. A review of the month of January 2026 revealed no ongoing data had been compiled to identify appropriate antibiotic usage, tracking for trends, clusters or outbreaks, ongoing surveillance, or staff education on infection control principles. Continued review of the monthly program data revealed the following: December 2025 There was no monthly summary that documented the prevalence of the different types of infection within the facility or a calculated infection rate. The facility's surveillance report documented 27 total infections. There were no documented signs and symptoms for any of the 27 infections to demonstrate they met the appropriate criteria for antibiotic usage. The report documented 17 infections (with no signs and symptoms) were treated with antibiotics, 3 infections were blank on whether they met criteria or did not meet criteria for antibiotic usage, and 7 infections were documented as meeting criteria for antibiotic usage despite no documented signs and symptoms. The report further documented 14 infections were healthcare-associated (developed in the facility), 4 developed prior to admission, and 9 were documented as developed, Other. It was also of note, December's data did not include any mapping for trends, clusters, or outbreaks. November 2025 There was no monthly summary that documented the prevalence of the different types of infection within the facility or a calculated infection rate. The surveillance report documented 28 total infections. There were no documented signs and symptoms to demonstrate whether any of the 28 met appropriate criteria for antibiotic usage. The report documented 9 infections were Acquired Prior, 3 were community acquired (outside of the facility), 10 were NA, and 6 were healthcare associated. It was unclear what the definition of Acquired Prior and NA meant. Further review of the report had No Response documented for all 28 infections in the Test Results and Test Type columns, and the Criteria Met column documented False for 21 infections and True for 7 infections despite no documented signs and symptoms. It was further noted No Response was documented in the Infection Type for 14 infections with the remaining 14 infections listing types such as: urinary tract infections, respiratory infections, blood stream infections, and skin infections. It was also noted the mapping for trends, clusters, and outbreaks only documented nine infections. It was unclear from the data what nine infections of the 28 total on the surveillance report were demonstrated on the mapping. October 2025 There was no monthly summary that documented the prevalence of the different types of infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	within the facility or a calculated infection rate. The surveillance report documented 36 total infections. There were no documented signs and symptoms to demonstrate whether any of the 36 met appropriate criteria for antibiotic usage. The report documented 9 infections were Acquired Prior, 4 were community acquired (outside of the facility), 8 were NA, 1 was Null, and 14 were healthcare associated. Further review of the report had No Response documented for 35 infections in the Test Results and Test Type columns, with one having a test result and test type logged. The Criteria Met column documented False for 13 infections and True for 23 infections despite no documented signs and symptoms. It was further noted No Response was documented in the Infection Type for 11 infections with the remaining 25 infections listing types such as: urinary tract infections, respiratory infections, blood stream infections, and skin infections. It was also noted the mapping for trends, clusters, and outbreaks only documented nine infections. It was unclear from the data what nine infections of the 28 total on the surveillance report were demonstrated on the mapping. On 1/28/26 at 12:11 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding the ongoing, comprehensive infection control program. The DON indicated the facility had four different infection control preventionists over the last year and didn't think they had the facility's best interests in mind. They indicated the data should list signs and symptoms of infections to demonstrate proper antibiotic usage and should accurately document whether residents admitted with infections or developed them in the facility. They further said the maps should be completed to demonstrate trends or outbreaks. They were asked about the terms Prior and NA documented in the Acquired columns and had no explanation saying infections can only be one of two ways, either a resident admits with an infection or develops it in the facility. The DON acknowledged the concerns with the program and indicated they had recently hired a new person for the position. On 1/28/26 at 3:32 PM, an interview was conducted with the facility's Administrator regarding the facility's Quality Assurance and Performance Improvement (QAPI) program. They were asked if they were aware of the status of the facility's infection control program and said they were not. They further volunteered the facility had been through several Infection Control Preventionists and the last person in the role did not report to the QAPI committee. A review of a facility policy titled, Infection Prevention and Control Program revised 12/27/23 was reviewed and read, Policy: This facility has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines . Linen Storage: On 1/27/26 at 8:35 AM, Environmental/Housekeeping Manager (Staff 'AA') was requested to observe the facility's back-up linen supply and they reported they didn't have a key and would have to contact the Administrator who had those keys. On 1/27/26 at 8:55 AM, the Administrator provided the keys to Staff 'AA'. On 1/27/26 at 9:00 AM, upon entry to the basement storage room, just outside and across from the elevator, there were two large metal carts that had linens and resident care equipment (heel protectors) that were not covered and stored on the cart. There were several shelves of linens that were visibly soiled with debris particles. Staff 'AA' reported those should have been covered and would have to order covers for those carts. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/27/26 at 9:05 AM, upon entry into the locked storage room, there were several metal wire racks with many items stored, including the facility's emergency water supply, back-up linens, covid tests, face masks, and blankets. The entire flooring was heavily soiled with dark stains, debris and trash scattered throughout the area. The ceiling was observed to have visible water damage with pieces of the ceiling that were broken, bubbling up and discolored. The ceiling particles were also observed in piles on the flooring, on top of the shelves, including the emergency water supplies. There were three cardboard boxes which were later identified to contain blankets stored directly under the pipes that ran across the ceiling with the visible water damage. Each of these boxes were compromised from the water damage. On 1/27/26 at 9:12 AM, the Administrator joined in on the observation of the basement storage room and confirmed the same observations as identified above. They were then asked to identify the belongings that were stored throughout the storage room. The Administrator reported they had not previously been aware of the current conditions of the storage room. According to the policy titled, Collection, Sorting, Handling, and Transportation of Soiled Linens dated 2025: .The workflow of laundry processes should be designed in a way that prevents cross-contamination .Clean linens should be sorted, packaged, transported, and stored in a manner that prevents the risk of contamination by dust, debris, and other soiled items . According to the policy titled, Handling Clean Linen dated 10/30/2023: .It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection . On 1/26/26 at 9:35 AM, R64's room door was observed with signage for Enhanced Barrier Precautions (EBP) (an infection control intervention to reduce transmission of multidrug-resistant organisms) and gowns and gloves, the prescribed Personal Protective Equipment (PPE). Respiratory Therapist (RT) NN was observed providing tracheostomy tubing care and checking oxygen levels for R64 wearing only a pair of gloves. After care, RT NN was observed exiting the room removed their gloves and did not perform hand hygiene. On 1/26/26 at 10:53 AM, RT NN was observed at the respiratory treatment cart where they donned gloves, removed items from the cart, entered the room of R10 which was observed with EBP signage and PPE. RT NN provided respiratory care, wearing only gloves, and did not perform hand hygiene after providing care. On 1/27/26 at 9:22 AM, the Room of R46 was observed with EBP signage and PPE. RT Manager Q was observed wearing only gloves providing respiratory care to R46. On 1/27/26 at 9:22 AM, RT Manager Q verified anytime respiratory is providing care, touching the residents, they must wear the proper PPE and stated they must gown up. RT Manager Q was informed of the above observations and acknowledged this was not appropriate. Review of the facility policy titled Personal Protective Equipment dated 12/2023 documented. .All staff who have contact with residents and/or their environments must wear personal protective (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	equipment as appropriate during resident care. Review of the facility policy titled Hand Hygiene dated 12/2023 documented. .All staff will perform proper hand hygiene procedures to prevent the spread of infection.