

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Mission Point Nursing & Physical Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Jeffrey Cedar Springs, MI 49319	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - 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 #3073173 & #3071679. Based on observation, interview, and record review, the facility failed to ensure transfers and toileting were completed per the care plan, and ensure staff implement facility policies and procedures for falls in 1 resident (Resident #101) of 4 residents reviewed for accidents/falls, resulting in harm when Resident #101 sustained multiple fractures to her left lower extremity after an unsafe transfer. Findings include: Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: fractures to right fibula (bone on the outside of the lower leg) and left calcaneus (heel bone). Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 6/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #101 had moderate cognitive impairment. Review of Resident #101's hospital X-rays dated 6/11/26 at 11:30 PM revealed, Left tibia (inner lower leg bone) and fibula (outer lower leg bone): Findings: No evidence of left tibiofibular (middle portion of lower leg bones) shaft fracture. Avulsed (pulled away from bone) bone fragment adjacent (next to) to the calcaneal (heel) bone. Impression: Avulsed fracture with bone fragment adjacent to the calcaneal bone. Left Ankle: Findings: questionable nondisplaced fracture of the medial (middle) aspect of the lateral malleolus (outer ankle or bony prominence on the bottom of the fibula) . Soft tissue swelling about the ankle joint. Impression: questionable nondisplaced fracture of the medial aspect of the lateral malleolus. Correlate with point tenderness. Review of Resident #101's Hospital Discharge Summary dated 6/16/26 revealed, .Hospital Course: .(x-rays) of right knee showed transverse nondisplaced fracture of proximal fibula. Workup additionally showed avulsed fracture of the left calcaneal bone. Questionable nondisplaced fracture of the left lateral malleolus. Orthopedic consulted and no acute surgical intervention indicated at this time with weight-bearing as tolerated for her bilateral lower extremities. Review of Resident #101's ADL (activities of daily living) Care Plan dated 6/16/26 revealed, the resident had deficits related to fracture of right fibula, multiple falls and obesity. Interventions included: assistance of 2 people with a hoist lift (a mechanical device used to safely lift and transfer using a sling and lifting system) for transfers, extensive assistance from 2 people for bed mobility, and dependent assistance from 2 people for toileting due to incontinence. It was also noted to offer a bed pan (a receptacle for urine and feces for bedridden people) if resident needs the bathroom urgently. Review Resident #101's Fall Care Plan dated 6/17/26 revealed, Resident #101 was at an increased risk for falls related to history of falls, fibula fracture, weakness, and anemia (not enough healthy red blood cells that can cause weakness). Interventions included: be sure the call light is within reach and encourage to use it for assistance and need for prompt response to all requests for assistance, initiated on 6/19/26; bed pan to be offered if resident is in bed and needs (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 0689 Level of Harm - Actual harm Residents Affected - Few	the bathroom urgently, initiated on 6/26/26. Review of Resident #101's Admissions Assessment dated 6/17/26 revealed that the resident was completely dependent on staff for transfers and toileting in the past 7 days and was at risk for falls due to history of falls, fall in the last month, fractures related to a fall, health conditions, and medications. Review of Resident #101's Fall Incident Report dated 6/23/26 at 8:00 AM revealed, .resident call bell was on, went to the room, resident was sliding off the bed and screaming she needs help. Staff was able to get resident back to bed. Resident remain in (sic) the legs on the floor but buttocks on the bed. Resident began to attempt to stand back up to go to the bathroom. Resident was 2 persons to the wheelchair as resident would not allow staff to get hoyer. Resident continued to stand up until she was transferred to the wheelchair. 2 staff members were able to transfer her safely to the toilet. Resident finished with the bathroom, staff was attempting to place hoyer pad under her to hoyer her back to the bed, but resident began to stand up. As the resident was transfer (sic) back to the wheelchair resident legs slide (sic) out from her and she was slowly lowered to the floor. Resident had gait belt on. Following the nurse approving the transfer the hoyer pad was placed under the resident, and she was hoyered back to the bed safely. Resident did not hit her head. Immediate Action Taken: bed pan to be offered if resident is in bed and needs the bathroom urgently. It was noted that the immediate action taken was an intervention in Resident #101's ADL care plan prior to the fall on 6/23/26. Review of Resident #101's facility X-ray of left foot & ankle dated 6/30/26 at 11:07 PM revealed, .Acute (New) distal diaphyseal (the lower shaft of the bone) fracture of fibula with comminution (shattered bone) and mild displacement (not aligned) seen. No joint dislocation. Soft tissue swelling noted .No comparison study. Conclusion: Acute distal diaphyseal fracture of fibula. Review of Resident #101's hospital Emergency Department Course dated 7/1/26 revealed, .7:13 PM Differential diagnosis includes acute fracture of fibula left side. Patient has a known right proximal (upper) fibular fracture. No evidence of cellulitis (skin infection). We will rule out DVT (blood clot) to that left side given the pain and swelling. 11:58 PM X-ray does show a medial and lateral malleolar (inside and outside of ankle) fracture along with a diaphyseal fracture of the fibula WHICH IS ALL NEW. Sounds like potentially the injury is from the facility or potentially an accident that happened at that facility. Patient is non weight bearing and will not be able to go home. Patient will be admitted .Review of Resident #101's hospital X-rays dated 7/1/26 at 7:54 PM revealed: Left tibia (bone on inside of lower leg responsible for weight bearing) and fibula (bone on outside of lower leg) Comparison: left lower leg radiographs (x-rays) from 6/11/26. Findings: There is an acute mildly comminuted fracture of the distal fibular diaphysis . There is mild soft tissue swelling in the left lower leg . Left ankle (lower leg where the fibula, tibia and foot bones come together) Comparison: Left ankle radiographs 6/11/26. Findings: The distal fibular diaphysis fracture (noted above) is again seen. There is a questionable fracture line involving the lateral malleolus (outside bone of the ankle) on the frontal projection. There is a bony irregularity involving the medial malleolus (inside bone of the ankle) on the oblique view compatible with a fracture. There is a soft tissue swelling about the ankle circumferentially . The final impressions were: 1. Acute mildly comminuted fracture of the distal fibular diaphysis. 2. Acute fracture of the medial malleolus. 3. Suspected acute fracture of the lateral malleolus. 4. Advanced atherosclerotic calcifications (dense calcium deposits). Review of Resident #101's hospital History & Physical dated 7/2/26 at 1:45 AM revealed, .presented to the (hospital name omitted) ED on 07/01/26 from her rehab facility in (city name omitted) with left ankle pain. History is limited given patient doesn't have a clear timeline of events. She was discharged from the hospital 06/16 after being admitted 06/11 for a mechanical fall with a right non-displaced proximal fibular fracture. She was seen by ortho (orthopedic doctor) and plan was to be WBAT (weight bearing as tolerated) .It sounds like at some point, patient had a fall at the SNF. She (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that they could not sit her back down on the toilet or get her to the chair, so they slowly lowered Resident #101 to the floor. CNA H reported that he went and got the hoier lift and they transferred Resident #101 to bed. CNA H reported that he did not notify the nurse about the incident until afterwards, and the nurse was busy; the nurse did not assess Resident #101 until later that day. In an interview on 7/29/26 at 11:13 AM, regarding Resident #101 accident on 6/23/26, LPN F stated, .apparently the aides had to lower (Resident #101) to the floor. LPN F reported that CNA J had informed her sometime after lunch that day about the incident, so she went in to check on Resident #101. LPN F reported that she did not complete a range of motion assessment and Resident #101's pain seemed typical for the resident. LPN F reported that she did not document the incident or report it to management and it was her understanding that if there were no injuries then it wasn't considered a fall. In an interview on 7/29/26 at 9:52 AM, Registered Nurse (RN) C reported that she did not typically work with Resident #101 but worked with her on 6/27/26 and 6/28/26. RN C reported that Resident #101 was extremely painful all over and they were administering oral and topical pain medications. In an interview on 7/29/26 at 10:11 AM, Physical Therapist (PT) K reported she worked with Resident #101 while the resident was at the facility. PT K reported Resident #101 needed extensive assistance of 2 staff to sit up in bed and to attempt to stand. PT K reported that Resident #101 had permission to stand and bear weight, but even with assistance, she could not stand or bear weight due to pain in her right leg and was not able to understand cueing to stand. PT K reported that Resident #101 was only able to get into a standing position with therapy staff physically holding her upright but did not put her feet on the ground or bear her own weight. PT K reported nursing and the provider were made aware on 6/25/26 of Resident #101's increase in pain and inability to tolerate therapy; then on 6/26/26 when Resident #101 was reporting left leg pain and talking about something that had happened in the bathroom, nursing staff was asked about a fall, but there was no record of it. PT K reported that on 6/29/26 they placed a CAM boot (a removable hard supportive boot used with fractures) on Resident #101's left foot and she was able to complete pedaling exercises at a very low level. PT K reported that on 6/30/26 Resident #101 was having a hard time following cues and had increased pain in her left leg. PT K reported Resident #101's x-ray on 6/30/26 showed a fracture of the left leg, therefore on 7/1/26 they did not attempt standing exercises. PT K reported that Resident #101's transfer status remained completely dependent on 2 staff and the mechanical hoier lift from admission on [DATE] until her discharge on [DATE], and Resident #101 was never found safe to stand or pivot for transfers. In an interview on 7/29/26 at 12:35 PM, PA M reported that Resident #101 admitted on [DATE] and was taking narcotic pain medication that was too heavy and caused her to be non-verbal and not able to participate in therapy. PA M reported that she had changed Resident #101's pain regimen and the resident was more alert. PA M reported that on 6/26/26 she had been informed of Resident #101's incident of being lowered to the floor, and PT K had remarked that Resident #101 was having increased pain in her left leg, so a topical pain medication was added. PA M reported that on 6/30/26 Resident #101 was complaining of increased pain in the left lower leg and there was warmth and induration (hardening and thickening of soft tissue, often due to inflammation, infection, or other underlying medical conditions) noted on exam which was treated with an antibiotic and ordered an x-ray. PA K reported that the x-rays showed a fracture and Resident #101 was ordered to wear a CAM boot on the left foot/lower leg, but then later that day was having increased pain and staff requested to have the resident sent to the hospital. In an interview on 7/29/26 at 1:33 PM, LPN G reported that on 6/26/26 staff from the therapy department were asking if Resident #101 had fallen because the resident kept talking about a fall. LPN G reported that after investigating it was found that CNA's had lowered her to the floor during a transfer. LPN G reported Resident #101 had x-rays (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the next week due to increasing pain in her left leg and the results showed a left leg fracture but did not show the left heel fracture that was listed in Resident #101's hospital records when she admitted to the facility. LPN G reported that the facility thought that the x-ray results may have reversed the left and right, and the fracture on the left was actually the known right leg fracture that Resident #101 admitted with. LPN G reported that Resident #101 was sent to the hospital on 7/1/26 to get clarification of the x-ray results. In an interview on 7/30/26 at 9:34 AM, DON B reported that he was first made aware that Resident #101 had fallen from the therapy director on 6/26/26 at 2:07 PM and determined later that day that the CNA's had attempted to transfer the resident and had to lower the resident to the floor. DON B reported that CNA J should have called for assistance prior to attempting to transfer Resident #101 to the toilet. DON B confirmed that Resident #101 had very brittle bones, was at high risk for fractures, and was not supposed to be physically transferred by the CNA's. DON B reported that Resident #101 was only supposed to be transferred using the mechanical hoist lift. DON B reported that the x-ray completed in the facility on 6/30/26 and at the hospital on 7/1/26 identified new fractures that were not on the x-rays from the hospital when Resident #101 admitted to the facility on [DATE]. In an interview on 7/29/26 at 8:20 AM, Nursing Home Administrator (NHA) A reported that when Resident #101's x-ray on 6/30/26 showed a fracture of the left leg, she thought it was the same fracture that was noted as questionable when she admitted and because the resident did not allege abuse the fracture was not reported. NHA A reported the allegation of abuse was reported on 7/6/26 based on FM L verbalizing that we caused Resident #101's left leg fractures. In a subsequent interview on 7/30/26 at NHA A reported that she was made aware on 6/26/26 that Resident #101 had sustained a fall after being transferred incorrectly by staff. Review of the facility policy Falls-Clinical Protocol dated 11/2/23 revealed, .2. Based on the assessment, an initial plan of care will be developed and implemented to address identified risks. This will be revised as necessary.5. Interventions should be developed and implemented per the assessed needs. Additional items to remember when developing the plan of care include: Resident's abilities and deficits, Balance (sitting/standing), adaptive equipment needs, proper use of mechanical lifts and transfer devices, .bathroom safety.8. For an individual who has fallen, staff should attempt to define possible causes within 24 hours of the fall. Once a fall occurs it is important to gather as much information as possible: observe for evident trauma. provide emergency care and assessment as indicated. The physician and responsible party should be notified as soon as the resident is stabilized. Document findings in the resident's medical record or EHR (electronic health record) per standard protocol. Complete the fall re-evaluation. An accident/incident report will be completed and forwarded to the DON (Director of Nursing).9. Post fall analysis items to be considered: .Review for med changes. Review for other acute clinical changes, Review staff and witness statements. Review of care plan and CNA (Certified Nursing Assistant) assignments/Kardex that were in place at time of fall. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: identification of root cause, assessment of all residents, re-education to all nursing staff, and initiation of weekly audits. The facility was able to demonstrate monitoring of the corrective action and maintained compliance		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the proper notifications were made for 4 residents (Resident #101, #102, #104 & #105) of 6 residents reviewed for notifications, resulting in the potential for a delay in care and worsening of medical conditions. Findings include: Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: fractures to right fibula (bone on the outside of the lower leg) and left calcaneus (heel bone). Review of Resident #101's ADL (activities of daily living) Care Plan dated 6/16/26 revealed, the resident had deficits related to fracture of right fibula, multiple falls and obesity. Interventions included: assistance of 2 people with a hooyer lift (a mechanical device used to safely lift and transfer using a sling and lifting system) for transfers, extensive assistance from 2 people for bed mobility, and dependent assistance from 2 people for toileting due to incontinence. Review of Resident #101's Fall Incident Report date of report 6/26/26, date of incident 6/23/26 at 8:00 AM revealed, .resident call bell was on, went to the room, resident was sliding off the bed and screaming she needs help. Staff was able to get resident back to bed. Resident remain in (sic) the legs on the floor but buttocks on the bed. Resident began to attempt to stand back up to go to the bathroom. Resident was 2 persons to the wheelchair as resident would not allow staff to get hooyer. Resident continued to stand up until she was transferred to the wheelchair. 2 staff members were able to transfer her safely to the toilet. Resident finished with the bathroom, staff was attempting to place hooyer pad under her to hooyer her back to the bed, but resident began to stand up. As the resident was transfer (sic) back to the wheelchair resident legs slide (sic) out from her and she was slowly lowered to the floor. Resident had gait belt on. Following the nurse approving the transfer the hooyer pad was placed under the resident, and she was hooyered back to the bed safely. Resident did not hit her head. Immediate Action Taken: bed pan to be offered if resident is in bed and needs the bathroom urgently. Agencies/People Notified: Administrator 6/26/26 at 2:07 PM, Family Member (FM L) 6/26/26 at 2:08 PM, DON (Director of Nursing B) 6/26/26 at 2:07 PM, Physician (Physician Assistant (PA) M) 6/26/26 at 2:07 PM. Review of Resident #101's facility X-ray of left foot & ankle dated 6/30/26 at 11:07 PM revealed, .Acute (New) distal diaphyseal (the lower shaft of the bone) fracture of fibula with comminution (shattered bone) and mild displacement (not aligned) seen. No joint dislocation. Soft tissue swelling noted. Conclusion: Acute distal diaphyseal fracture of fibula. Review of Resident #101's hospital Emergency Department Course dated 7/1/26 revealed, .7:13 PM Differential diagnosis includes acute fracture of fibula left side. Patient has a known right proximal fibular fracture. 11:58 PM X-ray does show a medial and lateral malleolar fracture along with a diaphyseal fracture of the fibula WHICH IS ALL NEW. Sounds like potentially the injury is from the facility or potentially an accident that happened at that facility. In an interview on 7/28/26 at 2:57 PM, Certified Nursing Assistant (CNA) J reported that Resident #101 was very difficult to move around in bed and it took at least 2 people to complete care for the resident. CNA J reported on 6/23/26 about 8:00 AM, Resident #101 was in her bed screaming for help and saying she needed to use the toilet. CNA J reported that she helped Resident #101 sit on the side of the bed, wrapped a gait belt around her waist, lifted her up and pivoted her into the wheelchair next to the bed. CNA J reported that she brought the resident into the bathroom and transferred her again the same way onto the toilet. CNA J reported that approximately 10 minutes later Resident #101 pressed the call light, and CNA J and CNA H attempted to stand and pivot Resident #101 from the toilet and into her wheelchair, but the resident (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said that she was too tired, so they sat her back down. CNA J reported they attempted to stand Resident #101 to put a hoier sling under her, but the resident was dead weight and they had to lower her to the floor. CNA J reported that while Resident #101 was on the floor they rolled her, side to side, to place a hoier sling underneath her, then transferred her back to bed using the hoier. CNA J reported that she informed Licensed Practical Nurse (LPN) F later that day about the incident. In an interview on 7/29/26 at 11:13 AM, regarding Resident #101 accident on 6/23/26, LPN F stated, .apparently the aides had to lower (Resident #101) to the floor. LPN F reported that CNA J had informed her sometime after lunch that day about the incident, so she went in to check on Resident #101. LPN F reported that she did not document the incident or report it to management and/or the physician, and it was her understanding that if there were no injuries then it wasn't considered a fall. In an interview on 7/29/26 at 12:35 PM, PA M reported that on 6/26/26 she had been informed of Resident #101's incident of being lowered to the floor on 6/23/26, and Physical Therapist (PT) K had remarked that Resident #101 was having increased pain in her left leg during therapy. In an interview on 7/30/26 at 9:34 AM, DON B reported that he was first made aware that Resident #101 had fallen from the therapy director on 6/26/26 at 2:07 PM and determined later that day that the CNA's had attempted to transfer the resident and had to lower the resident to the floor. Review of the facility policy Falls-Clinical Protocol dated 11/2/23 revealed, .8. For an individual who has fallen, .The physician and responsible party should be notified as soon as the resident is stabilized. Resident #102 Review of an admission Record revealed Resident #102 was originally admitted to the facility on [DATE], with pertinent diagnoses which included type 2 diabetes mellitus (chronic high blood sugar levels). Review of Resident #102's Progress Note dated 7/12/26 at 10:10 AM revealed, (Resident #102) was brought up to the front desk before breakfast, (Licensed Practical Nurse (LPN) G) mentioned needing to get a blood sugar before she went to the dining room cause remembered Friday pulling Humalog from backup for a 10 unit give with meals. Checked her blood sugar, which was 338. Checked her MAR (Medication Administration Record) and noted her insulin and blood sugar check had been discontinued. Put her blood sugar reading in, gave patient her medications and stated that it would be looked into today. After AM (morning) meds were finished, checked her orders and observed [NAME] (long-acting) and Humalog (sic) (should say Novolog) in the pending orders tab of the chart and under her orders as pending confirmation. Looked and they had been put in on 7/10/2026 at 9:10 PM by pharmacy. The [NAME] was to start at (9:06 PM) and the Novolog (fast-acting) at (9:09 PM) . Called (Registered Nurse (RN) C) on-call manager at 9:39 AM while trying to confirm the orders. this nurse put in a Humalog 10 unit order. and Gave the insulin to patient. The note did not indicate if the provider had been notified. In an interview on 7/29/26 at 1:08 PM, LPN G reported that when she worked on 7/12/26 she noticed that Resident #102 orders for blood sugar checks and/or insulin had been discontinued. After looking into it, LPN G reported that she found that the pharmacy had switched the name brand of Resident #102's insulin orders shortly after admission on [DATE] which in turn deleted the original orders for insulin and the new orders required confirmation from the nurse to be activated and visible in Resident #102's MAR. LPN G reported Resident #102 had only received insulin and a blood sugar check one time on 7/10/26 until the issue was identified on 7/12/26. LPN G reported she contacted the on-call manager, RN C to get assistance with activating the pending insulin orders; LPN G reported she did not contact the physician. In an interview on 7/30/26 at 10:14 AM, RN D reported that she had tried to pull Resident #102's insulin and other medications from the backup supply at the facility on 7/10/26 and they were not available. RN D reported that she did not notify the physician to report that the medications were not available to administer on 7/10/26 and she did not remember checking the pending confirmation tab on 7/10/26 and/or 7/11/26. In an (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 7/29/26 at 4:06 PM, RN C reported on 7/12/26 she was made aware Resident #102 had not received her insulin since 7/10/26 due to the pharmacy changing the orders on 7/10/26 and the orders being left in the pending confirmation. RN C did not notify the physician. Review of Resident #102's MAR revealed the following orders for insulin: Humalog insulin to be administered three times a day with meals beginning on 7/10/26 at 4:00 PM and discontinued on 7/10/26 at 9:09 PM. The record indicated LPN G administered one dose in the evening on 7/10/26 and Resident #102's blood sugar was 325. Novolog insulin was ordered on 7/10/26 at 9:09 PM to replace the Humalog, but the order was not confirmed until 7/12/26 at 9:57 AM. Toujeo insulin to be administered daily at bedtime beginning 7/10/26 at 7:00 PM. The order indicated not available on 7/10/26 by RN D and then discontinued on 7/10/26 at 9:06 PM. Lantus insulin was ordered on 7/10/26 at 9:06 PM to replace the Toujeo, but the order was not confirmed until 7/12/26 at 10:00 AM. In an interview on 7/30/26 at 8:50 AM, Director of Nursing (DON) B reported that RN D should have contacted that physician and got a replacement for Resident #102's Toujeo insulin when she identified that it was not available on 7/10/26 during the evening shift. Resident #104 Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: orthostatic (caused by standing up) hypotension (low blood pressure). Review of Resident #104's Care Plan initiated on 7/28/26 revealed, the resident had altered cardiovascular (heart and blood vessels) status related to hypotension with interventions that included: avoid taking blood pressure reading after physical activity or distress but did not indicate that the resident was prescribed medication for hypotension. Review of Resident #104's MAR revealed, Midodrine oral tablet 2.5 mg, give 1 tablet by mouth three times a day (upon rising, afternoon, bedtime) for hypotension. Start date 7/28/26. Resident #104 had received 7 of 7 opportunities for dose of the medication. There were no parameters for blood pressure written in the order. There was no order to check blood pressure. Review of Resident #104's Blood Pressure Results revealed the following: 7/30/26 at 12:14 PM: 98/63 7/30/26 at 4:36 AM 153/86 7/29/26 at 9:59 PM 99/58 7/29/26 at 8:08 AM 105/76 7/29/26 at 5:24 AM 112/61 7/28/26 at 11:17 AM 101/81 7/28/26 at 3:53 AM 96/63 In an interview on 7/30/26 at 12:30 PM Unit Manager (UM) E reported Midodrine medication was prescribed for low blood pressure (BP) and should always include parameters for BP in the orders, because the medication would only be administered when the resident's BP is low. UM E reported that Resident #104's Midodrine order was not written with parameters. UM E reported that the blood pressure should be checked before every dose is administered (upon rising, afternoon, and bedtime) to ensure it was within the recommended parameters. UM E reported that Resident #104's blood pressure checks do not correlate with when the medication was scheduled to be given, and the blood pressure was not being checked on regular intervals. In an interview on 7/30/26 at 12:26 PM, RN C reported that she had not received any information in report regarding Resident #104's Midodrine; she noticed there were no parameters in the medication order after she had already given the medication. Review of Resident #104's Progress Note dated 12:51 PM by RN C revealed, Nurse contacted PA (Physician Assistant) to request parameters for Midodrine as none provided. (PA M) requested parameters to not give medication if systolic over 120. Resident #105 Review of an admission Record revealed Resident #105 was originally admitted to the facility on [DATE], with pertinent diagnoses which included hypotension. Review of Resident #105's Care Plan created on 10/22/24 revealed, the resident had altered cardiovascular (heart and blood vessels) status related to hypotension with interventions that included: vital signs as tasked. Review of Resident #105's MAR revealed, Midodrine oral tablet 2.5 mg, give 1 tablet by mouth three times a day (upon rising, afternoon, bedtime) for hypotension systolic (top number of blood pressure) less than 90. Start date: 7/23/26. There was also a space to record the BP results with (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	each medication administration. Resident #105 received 7 of 21 opportunities for the medication and 5 of the 7 times that the medication was administered, the systolic BP was above 90. Review of Resident #105's Progress Notes related to physician notification and/or orders to administer Midodrine outside of ordered parameters. There was one note in the record on 7/28/26 at 6:52 PM indicating that Resident #105 had requested the medication be administered due to feeling dizzy. There was no documentation that the physician had been notified regarding the other doses of Midodrine that were administered outside of ordered BP parameters. In an interview on 7/30/26 at 12:22 PM, UM E reported that she was not aware Resident #105 was receiving his Midodrine outside of the physician ordered parameters. UM E reported that the nurse should be documenting that a physician had been notified prior to administering the medication. UM E reported that she could not find any documentation and/or secured messaging between the facility and the physician related to the Midodrine. UM E reviewed the MAR and confirmed that there were several times the medication was administered when the BP was outside of the physician ordered parameters. Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed, Hypotension is present when the systolic BP falls to 90 mmHg or below .for most people low blood pressure is an abnormal finding associated with illness .record any signs of BP alteration in nurses notes. Report abnormal findings to nurse in charge or health care provider. [NAME], P. A., [NAME], A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 461 and 465.		

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3071679Based on interview and record review, the facility failed to release medical records to the resident/resident representative in a timely manner for 1 resident (Resident #101), resulting in delayed access to a resident's medical records. Finding include:Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: fractures to right fibula (bone on the outside of the lower leg) and left calcaneus (heel bone). In an interview on 6/29/26 at 3:30 PM, Family Member (FM) L reported that she had submitted a request for medical records on 7/6/26 on behalf of Resident #101 and the facility had not contacted her regarding the records.Review of Resident #101's Authorization for the Release of Health Information revealed a request for medical records completed by FM L and signed by Resident #101. The document was dated 7/4/26.In an interview on 7/30/26 at 2:00 PM, Nursing Home Administrator (NHA) A reported that she had spoken to FM L today around noon and the records will be released 7/31/26. In a subsequent interview at 3:48 PM, NHA A reported that the records request was received on 7/6/26 but had been held up with the facilities legal team. NHA A reported that she had not been in contacted with Resident #101's family to communicate the delay until 7/30/26.		

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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 #3073173. Based on interviews and record review the facility failed to ensure timely reporting of an allegation of neglect for 1 resident (Resident #101) of 4 residents reviewed falls, when staff failed to follow Resident #101's care plan interventions for safe transfers, resulting in acute fractures to the resident's left lower leg and ankle. Findings include: Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: fractures to right fibula (bone on the outside of the lower leg) and left calcaneus (heel bone). Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 6/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #101 had moderate cognitive impairment. Review of Resident #101's ADL (activities of daily living) Care Plan dated 6/16/26 revealed, the resident had deficits related to fracture of right fibula, multiple falls and obesity. Interventions included: assistance of 2 people with a hooyer lift (a mechanical device used to safely lift and transfer using a sling and lifting system) for transfers, extensive assistance from 2 people for bed mobility, and dependent assistance from 2 people for toileting due to incontinence. It was also noted to offer a bed pan (a receptacle for urine and feces for bedridden people) if resident needs the bathroom urgently. Review Resident #101's Fall Care Plan dated 6/17/26 revealed, Resident #101 was at an increased risk for falls related to history of falls, fibula fracture, weakness, and anemia (not enough healthy red blood cells that can cause weakness). Interventions included: be sure the call light is within reach and encourage to use it for assistance and need for prompt response to all requests for assistance, initiated on 6/19/26; bed pan to be offered if resident is in bed and needs the bathroom urgently, initiated on 6/26/26. Review of Resident #101's Admissions Assessment dated 6/17/26 revealed that the resident was completely dependent on staff for transfers and toileting in the past 7 days and was at risk for falls due to history of falls, fall in the last month, fractures related to a fall, health conditions, and medications. Review of Resident #101's Fall Incident Report date of incident 6/23/26 at 8:00 AM revealed, .resident call bell was on, went to the room, resident was sliding off the bed and screaming she needs help. Staff was able to get resident back to bed. Resident remain in (sic) the legs on the floor but buttocks on the bed. Resident began to attempt to stand back up to go to the bathroom. Resident was 2 persons to the wheelchair as resident would not allow staff to get hooyer. Resident continued to stand up until she was transferred to the wheelchair. 2 staff members were able to transfer her safely to the toilet. Resident finished with the bathroom, staff was attempting to place hooyer pad under her to hooyer her back to the bed, but resident began to stand up. As the resident was transfer (sic) back to the wheelchair resident legs slide (sic) out from her and she was slowly lowered to the floor. Resident had gait belt on. Following the nurse approving the transfer the hooyer pad was placed under the resident, and she was hooyered back to the bed safely. Resident did not hit her head. Immediate Action Taken: bed pan to be offered if resident is in bed and needs the bathroom urgently. Review of Resident #101's facility X-ray of left foot & ankle dated 6/30/26 at 11:07 PM revealed, .Acute (New) distal diaphyseal (the lower shaft of the bone) fracture of fibula with comminution (shattered bone) and mild displacement (not aligned) seen. No joint dislocation. Soft tissue swelling noted .No comparison study. Conclusion: Acute distal diaphyseal fracture of fibula. Review of Resident #101's hospital Emergency Department Course dated 7/1/26 revealed, .7:13 PM Differential diagnosis includes acute fracture of fibula left side. Patient has a (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	known right proximal (upper) fibular fracture. No evidence of cellulitis (skin infection). We will rule out DVT (blood clot) to that left side given the pain and swelling.11:58 PM X-ray does show a medial and lateral malleolar (inside and outside of ankle) fracture along with a diaphyseal fracture of the fibula WHICH IS ALL NEW.Sounds like potentially the injury is from the facility or potentially an accident that happened at that facility.Patient is non weight bearing and will not be able to go home. Patient will be admitted .In an interview on 6/29/26 at 3:30 PM, Family Member (FM) L reported that Resident #101 admitted to the nursing home for rehabilitation for her right leg fracture and then was sent back to the hospital on 7/1/26 due to a left leg fracture. FM L reported that on 6/27/26 Resident #101 had told the family that she had fallen and then an aide stepped on her leg.In an interview on 7/28/26 at 2:57 PM, Certified Nursing Assistant (CNA) J reported that Resident #101 was very difficult to move around in bed and it took at least 2 people to complete care for the resident. CNA J reported on 6/23/26 about 8:00 AM, Resident #101 was in her bed screaming for help and saying she needed to use the toilet. CNA J reported that Resident #101 could not transfer onto the toilet in the bathroom using the hooyer lift, and she did not have a bedside commode. CNA J reported that she didn't have time to wait for assistance from another CNA or nurse because Resident #101 was trying to get out of her bed. CNA J reported that to her knowledge Resident #101 had never tried to get out of bed before that day and transferred only with the hooyer lift, unless therapy was performing the transfer. CNA J reported that she helped Resident #101 sit on the side of the bed, wrapped a gait belt around her waist, lifted her up and pivoted her into the wheelchair next to the bed. CNA J reported that she brought the resident into the bathroom and transferred her again the same way onto the toilet. CNA J reported that at that time, she instructed Resident #101 to press the call light when she was finished using the toilet and CNA J left the room. CNA J reported that approximately 10 minutes later Resident #101 pressed the call light, and CNA J and CNA H attempted to stand and pivot Resident #101 from the toilet and into her wheelchair, but the resident said that she was too tired, so they sat her back down. CNA J reported they attempted to stand Resident #101 to put a hooyer sling under her, but the resident was dead weight and they had to lower her to the floor. CNA J reported that while Resident #101 was on the floor they rolled her, side to side, to place a hooyer sling underneath her, then transferred her back to bed using the hooyer. CNA J reported that she informed Licensed Practical Nurse (LPN) F later that day about the incident. CNA J reported that in the days following the incident Resident #101 had been complaining of pain in her left leg but the nurses thought it was because she wasn't taking the strong pain medication anymore.In an interview on 7/29/26 at 12:00 PM, CNA H reported that CNA J had requested assistance with getting Resident #101 off the toilet and back into bed. CNA H reported that he and CNA J tried to stand Resident #101 up from the toilet, but the resident's legs gave out and she was complaining of pain. CNA H reported that they could not sit her back down on the toilet or get her to the chair, so they slowly lowered Resident #101 to the floor. CNA H reported that he went and got the hooyer lift and they transferred Resident #101 to bed. CNA H reported that he did not notify the nurse about the incident until afterwards, and the nurse was busy; the nurse did not assess Resident #101 until later that day.In an interview on 7/29/26 at 11:13 AM, regarding Resident #101 accident on 6/23/26, LPN F stated, .apparently the aides had to lower (Resident #101) to the floor. LPN F reported that CNA J had informed her sometime after lunch that day about the incident, so she went in to check on Resident #101. LPN F reported that she did not complete a range of motion assessment and Resident #101's pain seemed typical for the resident. LPN F reported that she did not document the incident or report it to management and it was her understanding that if there were no injuries then it wasn't considered a fall.In an interview on 7/30/26 at 9:34 AM, DON B reported that he was first made aware that (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #101 had fallen from the therapy director on 6/26/26 at 2:07 PM and determined later that day that the CNA's had attempted to transfer the resident and had to lower the resident to the floor. DON B reported that CNA J should have called for assistance prior to attempting to transfer Resident #101 to the toilet. DON B confirmed that Resident #101 had very brittle bones, was at high risk for fractures, and was not supposed to be physically transferred by the CNA's. DON B reported that Resident #101 was only supposed to be transferred using the mechanical hoist lift. DON B reported that the x-ray completed in the facility on 6/30/26 and at the hospital on 7/1/26, identified new fractures that were not on the x-rays from the hospital when Resident #101 admitted to the facility on [DATE]. In an interview on 7/29/26 at 8:20 AM, Nursing Home Administrator (NHA) A reported that when Resident #101's x-ray on 6/30/26 showed a fracture of the left leg, she thought it was the same fracture that was noted as questionable when she admitted and because the resident did not allege abuse the fracture was not reported. NHA A reported the allegation of abuse was reported on 7/6/26 based on FM L verbalizing that we caused Resident #101's left leg fractures. In a subsequent interview on 7/30/26 at NHA A reported that she was made aware on 6/26/26 that Resident #101 had sustained a fall after being transferred incorrectly by staff and did not report the incident to the State Agency.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3073173 & #3071679. Based on interview and record review, the facility failed to implement care planned interventions for transfers and toileting in 1 resident (Resident #101) of 4 residents reviewed for falls, resulting in Resident #101's fall with multiple fractures to her lower leg following an unsafe transfer. Findings include: Review of the facility policy Falls-Clinical Protocol dated 11/2/23 revealed, .2. Based on the assessment, an initial plan of care will be developed and implemented to address identified risks. This will be revised as necessary. 5. Interventions should be developed and implemented per the assessed needs. Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: fractures to right fibula (bone on the outside of the lower leg) and left calcaneus (heel bone). Review of Resident #101's ADL (activities of daily living) Care Plan dated 6/16/26 revealed, the resident had deficits related to fracture of right fibula, multiple falls and obesity. Interventions included: assistance of 2 people with a hooyer lift (a mechanical device used to safely lift and transfer using a sling and lifting system) for transfers, extensive assistance from 2 people for bed mobility, and dependent assistance from 2 people for toileting due to incontinence. It was also noted to offer a bed pan (a receptacle for urine and feces for bedridden people) if resident needs the bathroom urgently. Review Resident #101's Fall Care Plan dated 6/17/26 revealed, Resident #101 was at an increased risk for falls related to history of falls, fibula fracture, weakness, and anemia (not enough healthy red blood cells that can cause weakness). Interventions included: be sure the call light is within reach and encourage to use it for assistance and need for prompt response to all requests for assistance, initiated on 6/19/26; bed pan to be offered if resident is in bed and needs the bathroom urgently, initiated on 6/26/26. Review of Resident #101's Admissions Assessment dated 6/17/26 revealed that the resident was completely dependent on staff for transfers and toileting in the past 7 days and was at risk for falls due to history of falls, fall in the last month, fractures related to a fall, health conditions, and medications. Review of Resident #101's Fall Incident Report dated 6/23/26 at 8:00 AM revealed, .resident call bell was on, went to the room, resident was sliding off the bed and screaming she needs help. Staff was able to get resident back to bed. Resident remain in (sic) the legs on the floor but buttocks on the bed. Resident began to attempt to stand back up to go to the bathroom. Resident was 2 persons to the wheelchair as resident would not allow staff to get hooyer. Resident continued to stand up until she was transferred to the wheelchair. 2 staff members were able to transfer her safely to the toilet. Resident finished with the bathroom, staff was attempting to place hooyer pad under her to hooyer her back to the bed, but resident began to stand up. As the resident was transfer (sic) back to the wheelchair resident legs slide (sic) out from her and she was slowly lowered to the floor. Resident had gait belt on. Following the nurse approving the transfer the hooyer pad was placed under the resident, and she was hoyered back to the bed safely. Resident did not hit her head. Immediate Action Taken: bed pan to be offered if resident is in bed and needs the bathroom urgently. Review of Resident #101's facility X-ray of left foot & ankle dated 6/30/26 at 11:07 PM revealed, The bones appear diffusely demineralized. Acute (New) distal diaphyseal (the lower shaft of the bone) fracture of fibula with comminution (shattered bone) and mild displacement (not aligned) seen. No joint dislocation. Soft tissue swelling noted. Plantar (bottom of) and posterior (back side of) calcaneal bone spurs noted. No comparison study. Conclusion: Acute distal diaphyseal fracture of fibula. Review of Resident #101's hospital Emergency Department Course dated 7/1/26 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed, 7:13 PM Differential diagnosis includes acute fracture of fibula left side. Patient has a known right proximal fibular fracture. No evidence of cellulitis. We will rule out DVT (blood clot) to that left side given the pain and swelling. 11:58 PM X-ray does show a medial and lateral malleolar fracture along with a diaphyseal fracture of the fibula WHICH IS ALL NEW. Sounds like potentially the injury is from the facility or potentially an accident that happened at that facility. Patient is non weight bearing and will not be able to go home. Patient will be admitted. In an interview on 7/28/26 at 2:57 PM, Certified Nursing Assistant (CNA) J reported that Resident #101 was very difficult to move around in bed and it took at least 2 people to complete care for the resident. CNA J reported on 6/23/26 about 8:00 AM, Resident #101 was in her bed screaming for help and saying she needed to use the toilet. CNA J reported that Resident #101 could not transfer onto the toilet in the bathroom using the hoier lift, and she did not have a bedside commode. CNA J reported that she didn't have time to wait for assistance from another CNA or nurse because Resident #101 was trying to get out of her bed. CNA J reported that to her knowledge Resident #101 had never tried to get out of bed before that day and transferred only with the hoier lift, unless therapy was performing the transfer. CNA J reported that she helped Resident #101 sit on the side of the bed, wrapped a gait belt around her waist, lifted her up and pivoted her into the wheelchair next to the bed. CNA J reported that she brought the resident into the bathroom and transferred her again the same way onto the toilet. CNA J reported that at that time, she instructed Resident #101 to press the call light when she was finished using the toilet and CNA J left the room. CNA J reported that approximately 10 minutes later Resident #101 pressed the call light, and CNA J and CNA H attempted to stand and pivot Resident #101 from the toilet and into her wheelchair, but the resident said that she was too tired, so they sat her back down. CNA J reported they attempted to stand Resident #101 to put a hoier sling under her, but the resident was dead weight and they had to lower her to the floor. CNA J reported that while Resident #101 was on the floor they rolled her, side to side, to place a hoier sling underneath her, then transferred her back to bed using the hoier. CNA J reported that she informed Licensed Practical Nurse (LPN) F later that day about the incident. CNA J reported that in the days following the incident Resident #101 had been complaining of pain in her left leg but the nurses thought it was because she wasn't taking the strong pain medication anymore. In an interview on 7/29/26 at 12:00 PM, CNA H reported that CNA J had requested assistance with getting Resident #101 off the toilet and back into bed. CNA H reported that he and CNA J tried to stand Resident #101 up from the toilet, but the resident's legs gave out and she was complaining of pain. CNA H reported that they could not sit her back down on the toilet or get her to the chair, so they slowly lowered Resident #101 to the floor. CNA H reported that he went and got the hoier lift and they transferred Resident #101 to bed. CNA H reported that he did not notify the nurse about the incident until afterwards, and the nurse was busy; the nurse did not assess Resident #101 until later that day. In an interview on 7/29/26 at 11:13 AM, regarding Resident #101 accident on 6/23/26, LPN F stated, .apparently the aides had to lower (Resident #101) to the floor. LPN F reported that CNA J had informed her sometime after lunch that day about the incident, so she went in to check on Resident #101. LPN F reported that she did not complete a range of motion assessment and Resident #101's pain seemed typical for the resident. LPN F reported that she did not document the incident or report it to management and it was her understanding that if there were no injuries then it wasn't considered a fall. In an interview on 7/29/26 at 10:11 AM, Physical Therapist (PT) K reported she worked with Resident #101 while the resident was at the facility. PT K reported Resident #101 needed extensive assistance of 2 staff to sit up in bed and to attempt to stand. PT K reported that Resident #101 had permission to stand and bear weight, but even with assistance, she could not stand or bear weight due to pain in her right leg and was not (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able to understand cueing to stand. PT K reported that Resident #101 was only able to get into a standing position with therapy staff physically holding her upright but did not put her feet on the ground or bear her own weight. PT K reported that Resident #101's transfer status remained completely dependent on 2 staff and the mechanical hoier lift from admission on [DATE] until her discharge on [DATE], and Resident #101 was never found safe to stand or pivot for transfers. In an interview on 7/30/26 at 9:34 AM, Director of Nursing (DON) B reported that he was first made aware that Resident #101 had fallen from the therapy director on 6/26/26 at 2:07 PM and determined later that day that the CNA's had attempted to transfer the resident and had to lower the resident to the floor. DON B reported that CNA J should have called for assistance prior to attempting to transfer Resident #101 to the toilet. DON B confirmed that Resident #101 had very brittle bones, was at high risk for fractures, and was not supposed to be physically transferred by the CNA's. DON B reported that Resident #101 was only supposed to be transferred using the mechanical hoier lift. DON B reported that the x-ray completed in the facility on 6/30/26 and at the hospital on 7/1/26 identified new fractures that were not on the x-rays from the hospital when Resident #101 admitted to the facility on [DATE].		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of nursing practice for medication administration for 3 residents (Resident #102, #104 & #105) reviewed for the provision of nursing services, resulting in medication not administered following physician orders, the lack of assessment, monitoring, and documentation and the potential for the worsening of medical conditions. Findings include: Resident #102 Review of an admission Record revealed Resident #102 was originally admitted to the facility on [DATE], with pertinent diagnoses which included type 2 diabetes mellitus. Review of Resident #102's Baseline Care Plan revealed no baseline care plan developed for diabetes. Review of Resident #102's Hospital Discharge Summary dated 7/10/26 revealed, .Hospital Course: past medical history of DM (diabetes mellitus). Her sugars remained uncontrolled and her A1c (a blood test that shows the average blood sugar for the past 2-3 months) was 10.4 on admission (a level of 6.5 or higher is considered diabetic), so she will need stricter glucose control in the outpatient setting. Discharge Medications: Humalog (fast-acting) insulin, inject 10 units under the skin 3 times a day before meals. Toujeo (long-acting) insulin. inject 22 units under the skin at bedtime. Glucose (blood sugar) monitoring kit: use to test blood sugars daily. Review of Resident #102's Medication Administration Record (MAR) revealed the following orders for insulin: Humalog insulin to be administered three times a day with meals beginning on 7/10/26 at 4:00 PM and discontinued on 7/10/26 at 9:09 PM. The record indicated LPN G administered one dose in the evening on 7/10/26 and Resident #102's blood sugar was 325. Novolog insulin (fast-acting) was ordered on 7/10/26 at 9:09 PM to replace the Humalog, but the order was not confirmed until 7/12/26 at 9:57 AM. Three doses were missed on 7/11/26. Toujeo insulin to be administered daily at bedtime beginning 7/10/26 at 7:00 PM. The order indicated not available on 7/10/26 by RN D and then discontinued on 7/10/26 at 9:06 PM. One dose was missed on 7/10/26. Lantus insulin (long-acting) was ordered on 7/10/26 at 9:06 PM to replace the Toujeo, but the order was not confirmed until 7/12/26 at 10:00 AM. One dose was missed on 7/11/26. In an interview on 7/29/26 at 1:08 PM, LPN G reported that Resident #102 had admitted to the facility on [DATE] during her day shift and the admission orders were put in the computer by one of the managers that were helping. LPN G checked Resident #102's blood sugar that day before supper and administered Humalog as ordered before meals. LPN G reported that she did not work the next day, but when she worked on 7/12/26 she noticed that Resident #102 orders for blood sugar checks and/or insulin had been discontinued on 7/10/26. After looking into it, LPN G reported that she had discovered that the pharmacy had switched the name brand of Resident #102's insulin orders shortly after admission on [DATE] which in turn deleted the original orders for insulin and the new orders required confirmation from the nurse to be activated and visible in Resident #102's MAR. In an interview on 7/29/26 at 11:24 AM, LPN F reported that she worked with Resident #102 on 7/11/26 and was not aware that the resident had orders for insulin in the pending orders section of the MAR. In an interview on 7/30/26 at 10:14 AM, RN D reported that she had tried to pull Resident #102's insulin and other medications from the backup supply at the facility on 7/10/26 and they were not available. RN D reported that she did not notify the physician to report that the medications were not available to administer on 7/10/26 and she did not remember checking the pending confirmation tab on 7/10/26 and/or 7/11/26. Review of Resident #102's Blood Sugar Checks revealed, on 7/10/26 at 5:30 PM the blood sugar level was 325 and on 7/12/26 at 7:32 AM it was 338. According to American Diabetes Association Standards of Medical Care in diabetes - 2026 a normal blood sugar for adults with diabetes before meals ranges (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from 80-130. In an interview on 7/30/26 at 8:50 AM, Director of Nursing (DON) B reported that the pharmacy frequently replaces medication orders with equivalent medications that are available and preferred by insurance. DON B reported that it was the nurse's responsibility to check all medication orders for pending confirmation orders at the beginning of each shift. DON B reported that RN D should have contacted that physician and got a replacement for Resident #102's Toujeo insulin when she identified that it was not available on 7/10/26 during the evening shift; LPN F should have checked pending orders at the start of day shift on 7/11/26; RN D should have checked pending orders at the start of evening shift on 7/11/26; LPN G should have checked pending orders at the start of day shift on 7/12/26. DON B reported that all nursing staff have access and the responsibility to confirm orders and ensure the physician is notified if a resident does not receive ordered medication. DON B reported that Resident #102's insulin medication was ordered correctly and the nurses failed to confirm the orders. Resident #104 Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: orthostatic (caused by standing up) hypotension (low blood pressure). Review of Resident #104's Care Plan initiated on 7/28/26 revealed, the resident had altered cardiovascular (heart and blood vessels) status related to hypotension with interventions that included: avoid taking blood pressure reading after physical activity or distress but did not indicate that the resident was prescribed medication for hypotension. Review of Resident #104's MAR revealed, Midodrine oral tablet 2.5 mg, give 1 tablet by mouth three times a day (upon rising, afternoon, bedtime) for hypotension. Start date 7/28/26. Resident #104 had received 7 of 7 opportunities for dose of the medication. There were no parameters for blood pressure written in the order. There was no order to check blood pressure. Review of Resident #104's Blood Pressure Results revealed the following: 7/30/26 at 12:14 PM: 98/63/7/30/26 at 4:36 AM 153/86/7/29/26 at 9:59 PM 99/58/7/29/26 at 8:08 AM 105/76/7/29/26 at 5:24 AM 112/61/7/28/26 at 11:17 AM 101/81/7/28/26 at 3:53 AM 96/63 In an interview on 7/30/26 at 12:30 PM Unit Manager (UM) E reported Midodrine medication was prescribed for low blood pressure (BP) and should always include parameters for BP in the orders, because the medication would only be administered when the resident's BP is low. UM E reported that Resident #104's Midodrine order was not written with parameters. UM E reported that the blood pressure should be checked before every dose is administered (upon rising, afternoon, and bedtime) to ensure it was within the recommended parameters. UM E reported that Resident #104's blood pressure checks do not correlate with when the medication was scheduled to be given, and the blood pressure was not being checked on regular intervals. In an interview on 7/30/26 at 12:26 PM, RN C reported that she had not received any information in report regarding Resident #104's Midodrine; she noticed there were no parameters in the medication order after she had already given the medication. Review of Resident #104's Progress Note dated 12:51 PM by RN C revealed, Nurse contacted PA (Physician Assistant) to request parameters for Midodrine as none provided. (PA M) requested parameters to not give medication if systolic over 120. Resident #105 Review of an admission Record revealed Resident #105 was originally admitted to the facility on [DATE], with pertinent diagnoses which included hypotension. Review of Resident #105's Care Plan created on 10/22/24 revealed, the resident had altered cardiovascular (heart and blood vessels) status related to hypotension with interventions that included: vital signs as tasked. Review of Resident #105's MAR revealed, Midodrine oral tablet 2.5 mg, give 1 tablet by mouth three times a day (upon rising, afternoon, bedtime) for hypotension systolic (top number of blood pressure) less than 90. Start date: 7/23/26. There was also a space to record the BP results with each medication administration. Resident #105 received 7 of 21 opportunities for the medication and 5 of the 7 times that the medication was administered, the systolic BP was above 90. Review of (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #105's Progress Notes related to physician notification and/or orders to administer Midodrine outside of ordered parameters. There was one note in the record on 7/28/26 at 6:52 PM indicating that Resident #105 had requested the medication be administered due to feeling dizzy. There was no documentation that the physician had been notified regarding the other doses of Midodrine that were administered outside of ordered BP parameters. In an interview on 7/30/26 at 12:22 PM, UM E reported that she was not aware Resident #105 was receiving his Midodrine outside of the physician ordered parameters. UM E reported that the nurse should be documenting that a physician had been notified prior to administering the medication. UM E reported that she could not find any documentation and/or secured messaging between the facility and the physician related to the Midodrine. UM E reviewed the MAR and confirmed that there were several times the medication was administered when the BP was outside of the physician ordered parameters. Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed, Hypotension is present when the systolic BP falls to 90 mmHg or below. For most people low blood pressure is an abnormal finding associated with illness. Record any signs of BP alteration in nurses notes. Report abnormal findings to nurse in charge or health care provider. [NAME], P. A., [NAME], A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 461 and 465.		

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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 #3090808. Based on interview and record review the facility failed to ensure residents received care in accordance with professional standards for 1 resident (Resident #102) of 4 residents reviewed for quality of care, when nursing staff failed to ensure a newly admitted resident received monitoring and treatment for Type 2 diabetes mellitus (chronic high levels of sugar) resulting in missed insulin (medication that regulates blood sugar) doses, lack of blood sugar monitoring and the potential for worsening of health conditions and a delay in treatment. Findings include: Resident #102 Review of an admission Record revealed Resident #102 was originally admitted to the facility on [DATE], with pertinent diagnoses which included type 2 diabetes mellitus. Review of Resident #102's Baseline Care Plan revealed no baseline care plan developed for diabetes. Review of Resident #102's Hospital Discharge Summary dated 7/10/26 revealed, .Hospital Course: past medical history of DM (diabetes mellitus). Her sugars remained uncontrolled and her A1c (a blood test that shows the average blood sugar for the past 2-3 months). was 10.4 on admission (a level of 6.5 or higher is considered diabetic), so she will need stricter glucose control in the outpatient setting. Discharge Medications: Humalog (fast-acting) insulin, inject 10 units under the skin 3 times a day before meals. Toujeo (long-acting) insulin. inject 22 units under the skin at bedtime. Glucose (blood sugar) monitoring kit: use to test blood sugars daily. Review of Resident #102's Progress Note dated 7/12/26 at 10:10 AM revealed, (Resident #102) was brought up to the front desk before breakfast, (Licensed Practical Nurse (LPN) G) mentioned needing to get a blood sugar before she went to the dining room cause (sic) remembered Friday pulling Humalog from backup for a 10 unit give with meals. Checked her blood sugar, which was 338. Checked her MAR (Medication Administration Record) and noted her insulin and blood sugar check had been discontinued. Put her blood sugar reading in, gave patient her medications and stated that it would be looked into today. After AM (morning) meds were finished, checked her orders and observed [NAME] (long-acting) and Humalog (sic) (should say Novolog) in the pending orders tab of the chart and under her orders as pending confirmation. Looked and they had been put in on 7/10/2026 at 9:10 PM by pharmacy. The [NAME] was to start at (9:06 PM) and the Novolog (fast-acting) at (9:09 PM) . Called (Registered Nurse (RN) C) on-call manager at 9:39 AM while trying to confirm the orders. this nurse put in a Humalog 10 unit order. and Gave the insulin to patient. This note was created by Director of Nursing (DON) B. LPN G noted that the insulin medication names Novolog and Humalog are sometimes used interchangeably when referring to short-acting insulins but are not exactly the same. Review of Resident #102's Progress Note dated 7/12/26 at 12:03 PM by LPN G revealed, (Family Member (FM) S) was in this morning with questions about patient's insulin over the last few days. Attempted to answer questions (FM S) had to explain that I fixed (Resident #102's) insulin this morning and was not here to know what happened yesterday. Was told by CNA that (FM S) was at the front door leaving with (Resident #102). Resident #102 discharged from the facility AMA (against medical advice). In an interview on 7/29/26 at 1:08 PM, LPN G reported that Resident #102 had admitted to the facility on [DATE] during her day shift and the admission orders were put in the computer by one of the managers that were helping. LPN G checked Resident #102's blood sugar that day before supper and administered Humalog as ordered before meals. LPN G reported that she did not work the next day, but when she worked on 7/12/26 she noticed that Resident #102 orders for blood sugar checks and/or insulin had been discontinued on 7/10/26. After looking into it, LPN G reported that she discovered the pharmacy had switched the name brand of Resident #102's insulin medications shortly after admission on [DATE] which in turn deleted the original orders for insulin (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the new orders required confirmation from the nurse to be activated and visible in Resident #102's medication administration record. LPN G reported that Resident #102 had missed several doses of insulin and her blood sugar had not been checked since admission. LPN G reported that she contacted the on-call manager RN C for assistance but did not contact the physician at that time. LPN G reported that (FM S) was very upset when he discovered that Resident #102 had not received insulin for 2 days therefore, he immediately removed Resident #102 from the facility. In an interview on 7/29/26 at 11:24 AM, LPN F reported that she worked with Resident #102 on 7/11/26 and was not aware that the resident had orders for insulin in the pending orders section of the MAR. In an interview on 7/30/26 at 10:14 AM, RN D reported that she had tried to pull Resident #102's insulin and other medications from the backup supply at the facility on 7/10/26 and they were not available. RN D reported that she did not notify the physician to report that the medications were not available to administer on 7/10/26 and she did not remember checking the pending confirmation tab on 7/10/26 and/or 7/11/26. In an interview on 7/29/26 at 4:06 PM, RN C reported on 7/12/26 she was made aware Resident #102 had not received her insulin since 7/10/26 due to the pharmacy changing the orders on 7/10/26 and the orders being left in the pending confirmation. RN C reported that the nurses should be checking the pending confirmation tab at minimum once a shift. RN C did not notify the physician. Review of Resident #102's MAR revealed the following orders for insulin: Humalog insulin to be administered three times a day with meals beginning on 7/10/26 at 4:00 PM and discontinued on 7/10/26 at 9:09 PM. The record indicated LPN G administered one dose in the evening on 7/10/26 and Resident #102's blood sugar was 325. Novolog insulin was ordered on 7/10/26 at 9:09 PM to replace the Humalog, but the order was not confirmed until 7/12/26 at 9:57 AM. Toujeo insulin to be administered daily at bedtime beginning 7/10/26 at 7:00 PM. The order indicated not available on 7/10/26 by RN D and then discontinued on 7/10/26 at 9:06 PM. Lantus insulin was ordered on 7/10/26 at 9:06 PM to replace the Toujeo, but the order was not confirmed until 7/12/26 at 10:00 AM. Review of Resident #102's Blood Sugar Checks revealed, on 7/10/26 at 5:30 PM the blood sugar level was 325 and on 7/12/26 at 7:32 AM it was 338. According to American Diabetes Association Standards of Medical Care in diabetes - 2026 a normal blood sugar for adults with diabetes before meals ranges from 80-130. In an interview on 7/30/26 at 8:50 AM, Director of Nursing (DON) B reported that the pharmacy frequently replaces medication orders with equivalent medications that are available and preferred by insurance. DON B reported that it was the nurse's responsibility to check all medication orders for pending confirmation orders at the beginning of each shift. DON B reported that RN D should have contacted that physician and got a replacement for Resident #102's Toujeo insulin when she identified that it was not available on 7/10/26 during the evening shift; LPN F should have checked pending orders at the start of day shift on 7/11/26; RN D should have checked pending orders at the start of evening shift on 7/11/26; LPN G should have checked pending orders at the start of day shift on 7/12/26. DON B reported that all nursing staff have access and the responsibility to confirm orders and ensure the physician is notified if a resident does not receive ordered medication. DON B reported that Resident #102's insulin medication was ordered correctly and the nurses failed to confirm the orders. DON B reported the pharmacy frequently changes medication orders and nursing staff are very familiar with the practice of confirming pending medications. Review of Fundamentals of Nursing ([NAME] and [NAME]) revealed, Professional standards such as Nursing: Scope and Standards of Practice (ANA, 2010). apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these six rights: 1. The right medication 2. The (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 39307-39313). Elsevier Health Sciences. Kindle Edition. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: re-education to licensed nursing staff, resident assessments, and quality assurance audits. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.		