STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235296	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Southfield	26715 Greenfield Rd Southfield, MI 48076

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review the facility failed to ensure residents were treated with dignity during nursing care for one resident (R59) out of two residents reviewed for dignity/respect. Findings include:Based on observation, interview and record review the facility failed to ensure residents were treated with dignity during nursing care for one resident (R59) out of two residents reviewed for dignity/respect. Findings include:On 8/12/25 at approximately 9:16 AM, Certified Nursing Assistance (CNA) T was observed changing R59. There was no privacy curtain wrapped around the resident's bed. R59 shared a room with two other residents. One resident was ambulating around the room and was able to observe the resident being changed. The Surveyor was interviewing another resident and had the potential to view R59 during care. CNA T left the room and R59 was sitting on the side of the bed. Their call light was on the floor.Following the observation, Nurse K was asked about the call light on the floor and the failure of CNA T to ensure R59's privacy curtain was used. Nurse K lifted the call light off the floor and noted that while the privacy curtain should have been used, they believed it was not working and when they tried to pull it around the resident it was not working. Nurse K reported that they would ensure it was fixed. Nurse K was asked if they knew how long it was not in working correctly but was not able to provide a date.On 8/14/25 at approximately 12:05 PM, R59 was observed sitting in their room. They were asked if their privacy curtain had been fixed. R59 noted they believed so, but was not certain and noted that they were legally blind. When asked about the incident that occurred on 8/12/25, R59 reported that they were not happy that they were exposed during care.On 8/14/25 at approximately 12:50 PM, the Administrator was asked about the facility's protocol for ensuring privacy during care. The Administrator reported that nursing staff should ensure residents privacy during care and noted that they were not aware of the situation that occurred on 8/12/25 and would ensure the privacy curtain was working correctly and discuss the concern with staff.The facility policy titled, Promoting/Maintaining Resident Dignity (10/26/23) was reviewed and documented, in part: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life.All staff members are involved in providing care to residents to promote and maintain resident dignity.maintain resident privacy.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review facility failed to provide appropriate equipment (in a timely manner) for two residents (R176 & R177) of two residents reviewed for reasonable accommodation of needs. This deficient practice has the potential for accidents and improper care with feelings of frustration and dissatisfaction. Findings include:R176Record review revealed R176 was admitted to the facility on [DATE] for skilled rehabilitation and nursing needs after hospitalization. R176's admitting diagnoses included acute respiratory failure with hypoxia, Chronic Obstructive Pulmonary Disease (COPD), morbid obesity, diabetes and pulmonary embolism (blood clot in lungs). Based on Brief Interview for Mental Status assessment (BIMS) dated 8/11/25 revealed a score of 15/15, indicative of intact cognition.An initial observation was completed on 8/12/25 at approximately 9:20 AM. R176 was observed laying on their bed. A few minutes later they were observed from the hallway outside of their room. They were observed sitting on the edge of the bed. When the surveyor walked into room R176 was observed sitting on the bed frame on the left side of the bed and the mattress was pushed over to the right. They had a 4 wheeled walker in the front. R176 reported that they came over to the facility last Thursday from the hospital. The room had two regular chairs and a regular wheelchair folded up. R176 was queried if they were comfortable and why they were sitting on the bed frame. They reported they needed something to sit on, and they were unable to sit on the mattress as their feet wouldn't touch the ground with the mattress. They were asked if they were comfortable sitting on the edge of the bed and if they could sit on a chair. R176 reported that they needed an extra wide chair and wheelchair the facility did not have any. They added that they were not comfortable sitting for an extended period of time on the edge of the bed without any back support and they had to sit on the edge of bed to watch television on the left side of the bed. R176 reported that they had a wide recliner chair in the hospital and stated that I hope I get a chair soon. R176 was queried about if they had spoken with any staff and they reported the staff members were aware and were unsure why they did not have an appropriate chair/wheelchair to sit on. During the conversation R176 was leaning back and forth to get themselves comfortable.During a follow-up observation on 8/12/25 at approximately 11:25 AM (from the hallway), R176 was observed sitting on the edge of their bed. They were rocking back and forth a few times; then they leaned forward on to their 4 wheeled walker and stood up to stretch their back and sat back down. They appeared uncomfortable.Later in the afternoon another follow-up observation and interview were completed at approximately 1:10 PM. R176 was in their room in bed. During this interview R176 confirmed again their concern about not having an appropriate chair to sit on and no one had spoken with them or provided any updates.Review of hospital discharge summary and the internal admission notification revealed the R176's height, weight and their need for bariatric equipment prior to admission to the facility on 8/7/25.During an interview with the unit manager (UM) V on 8/13/25 at approximately 9:15 AM they were queried why R176 did not have an appropriate chair or wheelchair to sit in the room and observations of R176 sitting on the bed frame trying to get themselves comfortable; UM V reported that they were going to order R176 a bariatric bed that goes lower and a wider chair/wheelchair. When queried further why did R176 not have the appropriate equipment since they were admitted (7 days) they did not provide any further explanation. R177Record review revealed R177 was admitted to facility on 8/7/25 after hospitalization for skilled nursing care and rehabilitation services. R177's admitting diagnoses included exacerbation of Chronic Obstructive Pulmonary Disease (COPD), respiratory failure, Obstructive Sleep Apnea, morbid obesity, and hyperventilation syndrome. Based on Brief Interview for Mental Status Assessment (BIMS) dated 8/11/25, R177 had score of 15/15, indicative of intact cognition.An initial observation was completed on 8/12/25 at approximately 10:15 AM. R177 was observed in their bed. R177 was so close to the edge of the bed on the left side of the bed and there was approximately 3-4 inches of space on the right side of the bed. The bed did not have enough room to safely roll to the side. An initial interview was completed during this observation. They reported that they came over to the facility last Thursday. When queried about their bed to see if they were comfortable, R177 reported that the bed was too small and there was no room to turn; they had been lying flat on their back. They added that they were told that they were getting a wider bed on the day they were admitted to the facility, and they did not know why they still did not have one. They added that the bed did not have any bars to hold on and it was very tricky to turn in bed. They did not have a bariatric wheelchair or chair in their room. R177 had a roommate, and the room did not appear to have enough space to

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1194668.Based on record review and interview, the facility failed to purchase a surety bond in an amount equal to the current balance of personal funds held in the resident trust fund. This deficient practice has the potential to affect 82 resident's that have funds managed by the facility. Findings include:On [DATE] at 2:24 PM, the facility was requested to provide a list of residents that have personal funds managed by the facility (resident trust fund), and the facility's surety bond (an agreement between the principal [the facility], the surety [the insurance company], and the oblige [either the resident or the State acting on behalf of the resident], wherein the facility and the insurance company agree to compensate the resident (or the State on behalf of the resident) for any loss of residents' funds that the facility holds, safeguards, manages, and accounts for).Review of the documentation provided revealed the provided list of residents that had current balances as of [DATE] included Total Accounts: 82 .Current balance $63,240.36 . The facility's surety bond which was dated [DATE] - [DATE] documented it was only for $45,000.00.On [DATE] at 8:32 AM, an interview was conducted with the Business Office Manager (Staff ‘H‘) who reported they had been in their role for about a year. When asked about the residents included on the documentation that had money in the facility's resident trust fund, Staff ‘H' confirmed there was at least one resident that had expired [DATE] but was still showing as having funds. They reported they were not sure why that happened and would follow-up. When asked about the surety bond amount which was much lower than the current balance for [DATE], Staff ‘H' reported they would follow-up.On [DATE] at 10:40 AM, Staff ‘H' provided additional documentation and reported the trust fund balances from previous months were lower than $45, 000 and further reported they had not processed the patient pay amounts for the month of August yet, so it would be lower amount that what it was showing. Staff ‘H' was asked if there was a specific date the resident's patient pay amounts were removed for payment and they indicated there was not, and it varied. They were informed the current surety bond provided did not cover the current balance and remained a concern.On [DATE] at 1:15 PM, Staff ‘H' reported the facility's trust fund balance documentation of previous months were under $45,000 and they were still waiting to process patient pay amounts for the month. When asked if that usually occurs on a specific date, Staff ‘H' stated the dates varied for multiple residents. Staff ‘H' was informed the concern remained since the current balance of the resident trust fund was significantly higher than the amount of the surety bond.On [DATE] at 9:44 AM, the facility was requested to provide a policy regarding the surety bond. At 9:59 AM, the Administrator reported they did not have a policy regarding surety bond.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review facility failed to follow up timely about the grievances expressed by the resident and follow their grievance process for one (R177) of one resident reviewed for grievances. This deficient practice has the potential for dissatisfaction and frustration with the care/services received during their stay at the facility. Findings include: R177Record review revealed R177 was admitted to facility on 8/7/25 after hospitalization for skilled nursing care and rehabilitation services. R177's admitting diagnoses included exacerbation of Chronic Obstructive Pulmonary Disease (COPD), respiratory failure, Obstructive Sleep Apnea, morbid obesity, and hyperventilation syndrome. Based on Brief Interview for Status Assessment (BIMS) dated 8/11/25 R177 had score of 15/15, indicative of intact cognition.An initial observation was completed on 8/12/25 at approximately 10:15 AM. R177 was observed in their bed. R177 was so close to the edge of the bed on the left side of the bed and there was approximately 3-4 inches of space on the right side of the bed. An initial interview was completed during this observation. They reported that they came over to the facility last Thursday. When queried about the services and care, R177 reported that the facility staff were not very responsive when they needed help, especially at night and weekends. When they were queried further they added that they had to wait several hours for assistance over the weekend when they had called for help and they were very concerned. When queried if they had spoken with any facility staff member about their concern; R177 reported that they spoke with the nurses and they did not remember their names. When queried about their bed if they were comfortable, R177 reported that it was too small and there was no room to turn. They added that they were told that they were getting a wider bed on the day they were admitted to the facility and they did not know why they still did not have one. They added the bed did not have any bars to hold on and it was very tricky to turn in bed, even with staff assistance.A follow-up interview was completed with the resident later that day at approximately 2:45 PM. During the interview R177 confirmed they had concerns about longer waiting times and the over the weekend when they had to wait several hours for help. They had also confirmed that they had spoken with the staff and voiced their care concerns and their bed being too small.Review of R177, the Electronic Medical Record revealed a care plan dated 8/7/25. R177 needed two-person assistance with mobility in bed and toileting.An e-mail was sent to the facility administrator on 8/13/24 at 9:23 AM requesting the grievances and facility follow-ups for R177 since their admission to the facility. The facility did not provide any grievance reports. Review of R177's Speech Language Pathology evaluation dated 8/9/25 revealed that R177's executive function, memory, and problem-solving skills were within functional limits.An initial interview with Unit Manager (UM) V was completed on 8/13/25 at approximately 9:15 AM. UM V was queried if they were of aware of any concerns regarding R177. UM V stated Yes and they heard about it yesterday. When queried further they initially reported they heard about care concern from a Certified Nursing Assistant (CNA) that R177 waited a long time for staff assistance. UM V then stated that they heard the concern from a nurse, who worked on the unit, but they were not a regular nurse for the unit. When queried further they reported they went and spoke with R177 with their Regional Director of Operations (RDO). UM V also added that they interviewed the staff who had worked on the unit.A follow-up observation was completed on 8/13/25 at approximately 9:25 AM. R177 was observed in the same bed laying on their back. They were queried if anyone from the management team had spoken with him about the concerns they had and followed up. R177 reported several staff members have been coming in and out; they did not know who they were and no one had asked them about their concerns.A follow-up interview with the Unit Manager (UM) V was completed on 8/13/25 at approximately 1 PM when they had approached the surveyor. UM V reported that they had spoken with R177 and they did not have any concerns. UM V also added that R177 reported that they were getting the care but not thorough care that staff were not wiping the resident clean. When queried further about their follow up when they had the concern they reported that they should have initiated the grievance process and followed up.During an interview with R177's family member (who were listed as the 1st emergency contact) on 8/14/25 at approximately 8:20 AM, they reported that their father had expressed concern about long waiting time to get staff assistance and they had waited over 4 hours to get staff assistance on one occasion. R177's family member also added that their father informed them that facility staff members were aware of their care concerns. An interview with the facility administrator was completed on 8/13/25 at approximately 10:15 AM. During this interview the Regional Director of Operations (RDO) DD was present in the room. The administrator was queried if they were aware of R177's care concerns and

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2572077Based on interview and record review the facility failed to thoroughly complete a discharge summary for two residents (R172 and R173) of five residents reviewed for discharges. Findings include: R172 On 8/12/25 a concern submitted to the State Agency was reviewed which alleged R172 and R173 were inappropriately discharged from the facility. On 8/13/25 the medical record for R172 was reviewed and revealed the following: R172 was initially admitted to the facility on [DATE], had diagnoses including Edema and Cellulitis and was discharged on 9/7/24. A review of R172's MDS (minimum data set) with an ARD (assessment reference date) of 6/30/24 revealed R172 needed assistance from facility staff with most of their activities of daily living. R172's BIMS score (brief interview of mental status) was 15 indicating intact cognition. A review of R172's Discharge to Home/Community/AL(assisted living)/Equal Care Setting assessment (a documented provided to the resident upon discharge that has a summary of their care) revealed the following areas that were left blank on the form: B. Nutrition and Allergies-1.Diet ordered by physician at time of discharge: [Blank]. 2. Calorie Information and Special Instructions: [Blank] .4.Dietary Recap: [Blank]. 5. Name of Dietary Services person completing section: [Blank] .D. Activities. 1. Activities Recap: [Blank] 2. 2.Name of Activities person completing section: [Blank] .E. Nursing Summary: Skin/Wounds: [Blank] .Assistance with Care and Activities of Daily Living: 2. Dressing [Blank]. 3. Bathing [Blank]. 4. Eating [Blank] 5. Toileting [Blank] .Devices:7. Assistive Devices (check all that apply) [Blank]. Recap: 8. Nursing Recap [Blank]. 9. Name of Nursing person completing section [Blank]. F. Medications: .2. At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? [Blank]. 3. At the time of discharge to another provider, did the facility provide the resident's current reconciled medication list to the subsequent provider? [Blank] .J. Discharge Services and Equipment: 1. Home Care Agency-[Blank] .3. Meal Agency-[Blank]. 4. State Ombudsman (include contact number)-[Blank] .Equipment-[Blank] R173 On 8/13/25 the medical record for R173 was reviewed and revealed the following: R173 was initially admitted to the facility on [DATE], had diagnoses including Presence of Pacemaker and [NAME] insufficiency and was discharged on 9/7/24. A review of R173' MDS (minimum data set) with an ARD (assessment reference date) of 9/5/24 revealed R173 required set-up assistance or supervision from facility staff with their activities of daily living. R173's BIMS score (brief interview of [NAME] status) was 15 indicating intact cognition. A review of R173's Discharge to Home/Community/AL/Equal Care Setting assessment (a documented provided to the resident upon discharge that has a summary of their care) revealed the following areas that were left blank on the form: B. Nutrition and Allergies-1.Diet ordered by physician at time of discharge: [Blank]. 2. Calorie Information and Special Instructions: [Blank] .4.Dietary Recap: [Blank]. 5. Name of Dietary Services person completing section: [Blank] E. Nursing Summary: Skin/Wounds: [Blank] .Assistance with Care and Activities of Daily Living: 2. Dressing [Blank]. 3. Bathing [Blank]. 4. Eating [Blank] 5. Toileting [Blank] .Devices:7. Assistive Devices (check all that apply) [Blank]. Recap: 8. Nursing Recap: n.a 9. Name of Nursing person completing section: n.a F. Medications: .2.At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? [Blank]. 3. At the time of discharge to another provider, did the facility provide the resident's current reconciled medication list to the subsequent provider? [Blank] .J. Discharge Services and Equipment: 1. Home Care Agency-[Blank] .3. Meal Agency-[Blank]. 4. State Ombudsman (include contact number)-[Blank] .Equipment-[Blank] On 8/13/25 at approximately 3:16 p.m., during a conversation with Social Work Director C (SWD C), SWD C was queried regarding the mostly blank discharge forms for both R172 and R173 and the lack of clinical information that was provided up on discharge and they indicated that they did identify the same issue around that time with facility staff failing to complete the discharge form, SWD C reported that each discipline in the facility should have filled out their sections completely. On 8/13/25 a facility document titled Discharge Planning Process was reviewed and revealed the following: Policy: It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions 1. Upon discharge of a resident (other than in emergency to hospital or death) a discharge summary will be provided to the receiving care provider. The Discharge Summary should include a. An overview of the resident's stay that includes but not limited to: diagnoses

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #'s 1194664 and 1194670.Based on observation, interview and record review the facility failed to ensure residents received assistance with oral hygiene, incontinence care, bathing, and nail care for three (R8, R138, and R152) of seven residents reviewed for Activities of Daily Living (ADL). Findings include:R152 On 8/12/25 at 10:19 AM, R152 was observed lying in his bed with his hands on his chest. R152 was asked if he was able to move both arms. Upon R152 moving his left hand, that had been covering his right hand, it was observed the fingernails on R152’s right hand were approximately ½ to ¾ inches long. R152’s fingernails on his left hand were approximately ¼ to ¾ inches long. R152 was asked if he wanted his fingernails long. R152 explained he wanted them short, but no one at the facility had ever cut them. Review of the clinical record revealed R152 was admitted into the facility on 7/2/25 with diagnoses that included: dysphagia following cerebral infarction (difficulty swallowing after a stroke), hypertension and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R152 had severely impaired cognition. Review of R152’s ADL care plan revised 7/11/25, revealed R152 required assistance of staff for all ADL’s. On 8/13/25 at 9:49 AM, R152 was observed lying in bed. When asked about his fingernails, R152 showed both hands and the fingernails appeared to look the same. R152 was asked how often he received showers or bed baths. R152 explained he did not know. When asked what days he was supposed to get showers, R152 explained he did not know. Review of Certified Nursing Assistant (CNA) documentation for R152 revealed a task titled, “Bath on designated days” that only documented two bed baths, on 7/27/25 and 7/28/25. On 8/14/25 at 9:49 AM, CNA “S” was interviewed and asked where showers or bed baths were documented. CNA “S” explained it was documented in the computer. When asked who at the facility cut fingernails, CNA “S” explained the CNA’s cut fingernails. On 8/14/25 at 10:23 AM, CNA “T” and CNA “U” were interviewed and asked who cut fingernails. CNA “T” explained the CNA’s cut them. When asked how often fingernails were cut, CNA “U” explained fingernails were cut when they were getting long, or the resident requested them to be cut. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/25 at 10:25 AM, the Unit Manager (UM) for R52’s Unit, UM “V”, was interviewed and asked how often residents received a shower or bed bath. UM “V” explained residents received showers twice a week on set days, but could have them more often if they wanted. UM “V” was asked how often fingernails were cut. UM “V” explained some residents preferred them long, but all other residents’ nails should be cut when they were getting long. UM “V” was informed in the six weeks R152 had been at the facility, he had only received two bed baths. UM “V” explained she would look into that. Upon observation of R152’s fingernails with UM “V”, UM “V” asked R152 if he would let her cut his fingernails. R152 nodded his head to indicate agreement and explained he wanted them short. On 8/14/25 at 12:32 PM, R152 was observed with short fingernails. R152 explained he was happy they were cut, and he felt better. No additional documentation for R152’s showers or bed baths was provided prior to the end of the survey. R8 On 8/12/2025 at 10:19 AM, R8 was observed walking independently throughout the hallways, wearing a red bike helmet. When approached, R8 did not respond verbally, but smiled. On 8/12/25 at 12:20 PM, a phone interview was conducted with R8’s Legal Guardian (LG). When asked about whether they had any concerns with the resident’s care since they recently admitted into the facility, the LG reported they had concerns about the staff not brushing his teeth. They further expressed concern that prior to admission, the resident came from a horrible situation of neglect in an adult-living facility in which neglect was substantiated including neglect of oral care. The LG reported “I’m concerned about his teeth…His breath smelled really bad. I shouldn’t have to come and ask them to brush, that should be part of the routine.” When asked if anyone had reached out to them to discuss his refusals, or attempt to have them intervene if refusals continued, the LG reported they did not. Review of the clinical record revealed R8 was admitted into the facility on 7/14/25 with diagnoses that included: other disorders of psychological development, cerebral palsy, type 2 diabetes mellitus without complications, congenital cataract, abnormal weight loss, adult failure to thrive, and microcephaly. According to the Minimum Data Set (MDS) assessment dated [DATE], R8 had severe cognitive impairment, had no behavior concerns such as refusing care, has functional limitation in range of motion to one side of both upper and lower extremities, does not use a mobility device, and requires partial/moderate assistance with oral hygiene. Review of the section of the electronic medical record (EMR) for documentation of oral care over the past 30 days revealed oral care was done only once a day, or not at all. Documentation included: On 8/12/25 done at 22:59; On 8/11/25 at 09:03 (check marked as Resident Refused with no further follow-up); (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/10/25 done at 22:59; On 8/9/25 at 14:59 (check marked as “NO” for the question was oral care provided) and done at 22:45; On 8/8/25 at 8:56 (check marked as Resident Refused with no further follow-up) and done at 16:57; On 8/7/25 at 09:12 (check marked as Resident Refused with no further follow-up) and done at 17:30; There was no oral care documented for 8/5/25; On 8/3/25 at 09:37 (check marked as “NO” for the question was oral care provided) and done at 21:19; On 8/2/25 at 10:08 (check marked as Resident Refused with no further follow-up) and 17:16 (check marked as “NO” for the question was oral care provided); On 8/1/25 at 20:33 (check marked as “NO” with no further follow-up); There was no oral care documented for 7/31/25; On 7/30/25 at 09:37 (check marked as “NO” with no further follow-up) and done at 22:59; On 7/29/25 at 08:55 (check marked as Resident Refused with no further follow-up). The entries marked as NO and Resident Refused from 7/29/25 - 8/12/25 were all signed off by Certified Nursing Assistant (CNA ‘E’). R138 On 8/12/2025 at 10:36 AM, R138 was observed lying in bed with oxygen via nasal cannula. When asked about whether they had any concerns with receiving assistance with care, R138 reported concerns with incontinence care and stated “You only get changed once in an eight hour shift…Most of the time when I get changed, it’s just before they (Nursing Assistants) go home, maybe 2:30 PM. They say I’m heavy and difficult to change and can’t do without help…They’re also giving me water pills so you know I need to be changed more than once.” Review of the clinical record revealed R138 was admitted into the facility on [DATE], discharged on 3/6/25 and readmitted on [DATE] with diagnoses that included: chronic respiratory failure with hypoxia, morbid obesity due to excess calories, and contracture of muscles in right and left lower leg. According to the MDS assessment dated [DATE], R138 had intact cognition, had no behavior concerns (such as refusal of care), was always incontinent of bowel and bladder, and was not on a bowel toileting program. According to the profile section, R138 was identified as their own responsible party for both clinical and financial decisions. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the task section of the EMR which documented if shower/baths were given included: “ADL-I prefer shower/Sponge bath Wednesdays and Saturdays. The documentation for the past 30 days included only two entries on 7/16/25 and 8/13/25. The sections for 8/2, 8/6 and 8/9 were left blank. Further review of the documentation for R138’s “Bladder Elimination” section of the EMR prompted direct care staff to document Qshift (Day 7:00 AM - 3:00 PM, Evening 3:00 PM - 11:00 PM, and Night 11:00 PM - 7:00 AM). However upon review of the documentation, there were multiple blank (incomplete) entries that coincided with the concerns reported by R138 which included: On 8/2 day and evening shift (blank); On 8/3 day and night shift (blank); On 8/4 evening shift (blank); On 8/5 day shift (blank); On 8/6 day shift (blank); On 8/9 day and evening shift (blank); On 8/10 day shift (blank); On 8/11 day and evening shift (blank). On 8/14/25 at 11:30 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's expectations for documenting resident care provided, the DON reported it should be put in as “real time” (when care was actually provided). When asked if the EMR system alerted the facility if there were missed opportunities for ADL documentation and they reported in the morning they get a report that shows a percentage per unit and the expectation is to have better than 85% and should flag if for example no shower was given or if it was refused. The DON then pulled up the task sections of the EMRs for both R8 and R138 and reported they saw the same limited documentation for bathing, incontinence care and oral care. When asked what should happen if a resident refused care such as bathing, incontinence care, or oral care and the DON stated anyone who refuses should immediately let the nurse know and then follow up later. The DON further stated “We usually ask three times.” The DON reviewed R8's oral care documentation of refusals and when asked why it was marked as No for if oral care was provided but not noted as refused, and also about all the refusals or “No” responses were from the same CNA (CNA ‘E’) the DON reported they had no idea and would have to follow-up with that CNA. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/25 at 1:17 PM, a phone interview was conducted with CNA ‘E’. When asked about their documentation of “No” oral care and refusals, CNA 'E' reported the resident did not allow them to brush their teeth and always refused for them. When asked what they did when the resident refused oral care, i.e., did they notify anyone, CNA 'E' reported they no, they just documented refused and “No” in the electronic medical record. According to the facility's policy titled, Activities of Daily Living (ADLs) dated 12/28/2023: .A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, interview and record reviews the facility failed to adequately assess/monitor residents experiencing identified changes of condition, notify the Physicians of their continued decline and transfer the residents to higher levels of care in a timely manner, for four residents (R7, R97, R168 and R175) of four residents reviewed for changes in condition, resulting in R7 not being transferred to a higher level of care and expiring, R97 having a critically low hemoglobin level and expiring, R168 having to be transferred to the hospital and subsequently intubated and R175 contracting sepsis resulting in shock. These deficient practices resulted in the increased likelihood of serious harm, serious injury and/or death to occur. Findings include:The Immediate Jeopardy (IJ) began on [DATE] when the facility staff failed to implement Physician ordered interventions for R7 who had an identified change of condition including tachycardia and timely notify the Physician of the continued decline.The IJ was identified on [DATE] and the Administrator was notified of the Immediate Jeopardy on [DATE] at approximately 2:11 PM. A plan of removal was requested at that time to remove the immediacy.The surveyor team confirmed by Observation, Interview and Record review that the Immediate Jeopardy was removed on [DATE] based on the facility's implementation of an acceptable plan of removal. The noncompliance remains at an isolated event with the potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency (SA).R168 On [DATE] the medical record for R168 was reviewed and revealed the following: R168 was initially admitted to the facility on [DATE] and had diagnoses including Paroxysmal atrial fibrillation, Cardiac arrest and Hypertension. A review of R168's MDS (minimum data set) with an ARD (assessment reference date) of [DATE] revealed R168 was dependent on staff for most of their activities of daily living. R168's BIMS score (brief interview for mental status) was zero indicating severely impaired cognition. A Physican progress note dated [DATE] revealed the following: . pt (patient) seen for routine f/u (follow-up) after recent admission to this facility for long term care and possible rehab. Per chart review, pt had recent prolonged hospitalization at [name of local hospital] after suffering a cardiac arrest on [DATE] due to a large pulmonary embolism. He underwent 4 cycles of CPR (Cardiopulmonary resuscitation) .underwent mechanical thrombectomy for PE (Pulmonary embolism) .CVS (cardiovascular system): s1/s2 audible, tachycardia .4. A-fib/sinus tachycardia. -continue Xarelto and BBs (beta blockers). Add Cardizem for better BP (blood pressure) and rate control. -recent Echo 6/2025 preserved EF (ejection fraction) 60-65% .-d/w (discussed with) RD (Registered Dietician) and LPN (Licensed Practical Nurse) to increase FWF (free water flushes) to 250 q (every) 6 hrs (hours) in addition to TF (tube feeding). 5. HTN(Hypertension) /elevated BP. -continue Metoprolol, add Cardizem. 6. Dysphagia 2/2 #1 s/p (status/post) peg (percutaneous endoscopic gastrostomy) tube. -continue TF (tube feeding) per RD, increase FWF (free water fluids) to 250 q (every) 6 hrs (hours).POC (plan of care) d/w LPN, check routine labs, add CCBs (calcium channel blockers). A review of R168's Physican orders revealed R168's Cardizem was never administered to them and the increase of FWF to 250 Q 6 hours was never transcribed to the electronic Physican orders. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R168's Beats per minute (BPM's) revealed the following abnormal pulse vitals. [DATE] at 01:36 (139 PBM), [DATE] at 14:15 (138 BPM), [DATE] at 13:00 (138 BPM), [DATE] at 12:52 (138 BPM), [DATE] at 06:16 (138 BPM), [DATE] at 16:58 (126 BPM), [DATE] at 14:04 (132 BPM), [DATE] at 10:48 (144 BPM), [DATE] at 05:54 (130 BPM, [DATE] at 17:53 (138 BPM), [DATE] at 14:11 (137 BPM), [DATE] at 05:11 (136 BPM). A review of R168's progress notes revealed the following: [DATE] at 12:57-Note Text: Cardizem LA Tablet Extended Release 24 Hour 240 MG Give 1 tablet by mouth one time a day for HTN/Afib/tachycardia-not available [DATE]-Note Text: Writer checked resident’s vitals BP 122/87, HR (heart rate) 139 BPM, Temp: 97.5 F, SPo2 (oxygen saturation) 85%, Resp 39 breaths/min, BS (blood sugar) 196. Placed resident on 4L (liters)of oxygen via NC (nasal cannula). Did not do breathing treatment as HR was 139. Attempted to call MD (Medical Doctor), no answer. EMS (Emergency Medical System) called. Resident transferred to gurney by 3 paramedics and transported to [local hospital) by ambulance . [DATE]-Note Text: chief complaints/ History of present illness Call received from the nearest recording patience and becoming very short of breath and hypoxic and tachycardic with heart rates going up to 139 and pulse ox amateur and down to 85%And the time did not appear to be febrile Review of systems Patient not able to consistently answer/able to tell symptoms .Physical exam as listed above patient was . tachycardic otherwise unchanged from the past Assessment and planAcute hypoxia and tachycardia with shortness of breath /respiratory distress -patient was transferred to [local hospital] by EMS With help of the nurse on duty . [DATE]-Note Text: Addendum Pt (patient) in [local hospital] .-still appearing very short of breath and hypoxic /tachycardic with temperature of 102°F -requiring intubation/ventilation . On [DATE] at approximately 1:48 p.m., Physician QQ was interviewed pertaining to R168 being sent out to the hospital on [DATE]. Physican QQ indicated that on [DATE] they had ordered the cardizem and increase of FWF to 250 to try to bring down R168's heart rate and that they had thought that the orders had been entered into the electronic record. On [DATE] at approximately 4:49 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the Cardizem and FWF and reported that the orders should have been entered by the doctor or the Nurse that they had spoken with. The DON was queried regarding the cardizem not being available on [DATE] and they indicated that it is available in the back up and should have been administered. The DON was queried regarding R168's abnormal BPM's for the four days leading up to them being sent out to the hospital and they indicated that there should have been follow-up from the Nurses with the Physican to address it. Complaint # 2587232 Resident 97 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] a review of the record revealed that R97 was re-admitted to the facility on [DATE] with the diagnosis of End stage renal disease, anemia, renal dialysis with a brief interview for mental status score (BIMs) of 15 which indicated no cognitive impairment. A further review of the record revealed that R97 had a critically low hemoglobin of 5.7 on [DATE] and was sent to the hospital on [DATE]. R97 had a history of low hemoglobin as well as a history of being sent out to the hospital for the low levels. On [DATE] at 11:23 AM, a telephone interview was conducted with Family member “KK”, they were asked if they had any additional information, they would like to add to the complaint that was submitted to the state agency (SA). Family member “KK” reported that their sibling had expired in the hospital at 11:33 PM on [DATE] with a hemoglobin level of 3.2. Family member “KK” reported that the facility was aware of the low blood levels and would check them weekly. The facility was also good at sending R97 to the hospital when the hemoglobin level was about 5. Being Jehovah’s Witness, R97 would have refused a blood transfusion (per religious belief) but the hospital usually would give them iron and do other bloodless options to bring the hemoglobin to a stable level. Family member “KK” reported, that R97's hemoglobin had been a constant problem and when their hemoglobin was at 5 or lower, they would start to get confused and tired. Family member “KK” was asked, would R97, have wanted to be transferred to the hospital? Family member “KK” replied, Yes, she always went out. On [DATE] at 2:20 PM, an interview with Nurse “G”, was conducted and asked how did R97 present to them during their shift. Nurse “G” reported that R97 did not look well during their shift, but they continued to monitor the resident because the medical providers were aware of the critically low Hemoglobin of 5.7 and gave no new orders. R97 was alert and oriented and seemed to be at their baseline, just more tired since resident was dialyzed the day prior, so it was normal for them. R97, remained stable for the duration of their shift reported Nurse “G”. On [DATE] at 2:25 PM, an interview with the Director of Nursing (DON) was conducted. They were asked what the facility process was on change in conditions. The DON reported that they write a progress note and start a significant change. The significant change would be followed up with a meeting every Tuesday, Wednesday, and Thursday until the residents either get better or sent to a higher level of medical help. The DON was then asked about the process of reporting critically low lab levels. The DON reported that they notify the provider immediately to see if they wanted to add or change any orders or want the resident sent to the hospital, we also would put a progress notes in and start an SBAR(situation, background, assessment, and recommendation) tool. The DON was then asked, was staff expected to use current vital signs and documentation for the SBAR tool, the DON replied, yes. A review of the record revealed that on [DATE] at 7:22 PM a progress note was created and stated, “Resident labs came back, and hemoglobin is 5.72 and hematocritis [sic]19.6. HCP (healthcare provider) notified, no new orders.” On [DATE] at 6:40 PM a SBAR Commnication form and progress note was completed for the transfer to hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:27 PM, an interview with Nurse Practitioner (NP) “II” was conducted. They were asked if they were notified for R97's critical hemoglobin level, the NP replied, No. NPII reported that they worked closely with NP “JJ” with R97's plan of care. NP “II” reported that R97 had a history of low hemoglobin levels and was a Jehovah’s Witnesses, refused blood transfusions and would get sent right back to the facility after being evaluated by the hospital. NP “II” was asked, why R97 was not sent to the hospital for the critical lab levels. NP “II” reported that they were unsure and if they were aware of the lab value they would have sent R97. NP “II” stated that they sent everyone to the hospital with critical lab values regardless of their religion, unless they refused to go. On [DATE] at 3:00PM, an interview with NP “JJ” was conducted, they were asked were they notified of the critical lab value for R97? NP “JJ” reported that they were notified of the critical lab value and since R97 was Jehovah’s witnesses and usually refused blood transfusions, they were not sent to hospital. NP “JJ” reported that they called the dialysis unit in an attempt to collaborate with the provider to see if they would order iron infusion on the day of their dialysis. NP “JJ” was asked did they physically assess R97, NP “JJ” reported they had not but they did ask the nurse if R97 was on their menstrual cycle or had any bleeding from anywhere and had them follow up if anything changes. The next day I called NP “II” but they informed them that R97 had been transferred to the hospital. NP “JJ” was asked why did they not send R97 to the hospital. NP “JJ” reported that, R97 did not accept blood products and at the time of being notified R97 was asymptomatic and if R97 experienced symptoms they would have sent them to hospital. On [DATE] at 9:35 AM, an interview with the DON was conducted, they were asked to provide documentation for the SBAR, the change in condition, documentation/care plan that stated they refused to go to the hospital for critically low hemoglobin. The DON reported that they would look into it. No additional information was provided by exit of survey. R7 Clinical record review revealed R7 was admitted to the facility on [DATE] for rehabilitation and Nursing care. R7 had an impaired genitourinary (urinary organs) status related to ESRD (End-Stage Renal Disease) and received in house dialysis on Tuesday, Thursday and Saturday. R7 required a tracheostomy (surgical opening in the windpipe to assist with breathing), and had impaired cardiovascular status related to hypertension. R7 was alert, oriented and capable of making their needs known. A Brief Interview of Mental Status (BIMS) scored 15/15, signifying R7 was cognitively intact. A record review of a Nursing Progress note dated [DATE] at 5:55 AM, authored by Licensed Practical Nurse (LPN) “X” documented R7 expressed they wanted to be sent to the hospital due to feeling short of breath, and their breathing “…just felt off…” and had a Blood Pressure (BP) reading of 146/110. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:40 PM, a telephone interview was conducted with LPN “X” who recalled the incident and remarked they were a newer Nurse and not familiar with tracheostomies and relied on R7 who explained to them they felt like they had a “plug” deep down and performed suctioning with little to no secretions. LPN “X” contacted the on-call Provider on [DATE] around 6:30-7:00 AM, (was not sure of the name) told them R7 was requesting to go to the hospital and commented R7 always wants to go to the hospital. LPN “X” remarked the comment was posed as if R7 liked to “cry wolf”. LPN “X” took orders to give a one-time dose of Clonidine (medication to treat high blood pressure), a breathing treatment and Tylenol and have day shift reassess. Record review of the Medication Administration revealed the Clonidine documented within the progress note, was not documented as an order and not documented as given. Per Regional Clinical Director “BB”, an override report from Pharmacy Liaison “CC” was pulled from [DATE] to [DATE] and confirmed the verbal order for R7 to be administered Clonidine on [DATE] was not pulled as an override. On [DATE] at 12:20 PM, the Medical Director explained when on call Providers are contacted on off hours they are triaged, and a daily report is generated for the entire Provider team. The Medical Director explained the On Call Triage Provider was Nurse Practitioner (NP)“HH”. Per the Medical Director, there was no follow up with R7 on [DATE] and on Thursday [DATE]. NP “Z” who typically sees residents at this facility had a last-minute emergency and Attending Physician “AA” was on call but did not see Residents that day, therefore R7 did not have a Provider assess them in person. Nursing documented R7 still did not feel well, so much so they did not want to go to Dialysis. And no documentation reflected a Provider was contacted that R7 was still not feeling well and refused to attend dialysis. The Medical Director remarked if they had seen them, they would have been more concerned about them refusing dialysis due to risk of volume overload and would have either convinced them to have dialysis in-house or send them out l as they were requesting and receive dialysis at the hospital. On [DATE] at 1:16 PM, a telephone interview with Regional Dialysis Manager “W” provided documentation that R7’s scheduled dialysis for Thursday [DATE] was rescheduled due to R7 was not feeling well. Record review of the Progress notes dated [DATE] and [DATE] revealed no documentation or thorough follow up from a Provider or Nursing what R7’s change of condition entailed and why they were not feeling well. On [DATE] at 10:38 AM, a telephone interview with Certified Nurse Assistant (CNA) “Y” confirmed they were familiar with R7 and remarked they were so nice and called them their “buddy”. R7 could tell you what they wanted and recalled that they wanted to go to the hospital. Per CNA “Y” they went into R7’s room on [DATE] around 3:00 AM observed them up, they requested water and was watching television. Per CNA “Y” they went in around 6:30 AM and R7 was observed unresponsive and a Code Blue (a code for a life-threatening medical emergency) was called, and CPR (Cardiopulmonary Resuscitation) was initiated. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the State of Michigan Certificate of Death documented R7 was pronounced dead at the facility on [DATE] at 7:07 AM due to End Stage Renal Disease. R175 On [DATE] at 10:50 AM, R175 was observed lying in her bed with a low air loss mattress receiving oxygen through a tracheostomy (surgical hole in the windpipe). Two poles were observed in the room, one with tube feed infusion equipment and the other with intravenous (IV) infusion equipment. R175 did not respond to questions asked. Review of the clinical record revealed R175 was originally admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: diabetes, tracheostomy status and toxic encephalopathy. According to the BIMS staff assessment dated [DATE], R175 had severely impaired cognition. Review of R175’s progress notes revealed: An admission note dated [DATE] at 6:56 PM read in part, “…resident was admitted to (local Long Term Acute Care -LTAC- hospital) for metabolic encephalopathy underlying sepsis…” A nursing note dated [DATE] at 11:33 PM by RN “Q” read in part, “Resident vitals were 126/68 HR (heart rate) 135 spO2 [sic] (percent of oxygen in the blood). Writer notified physician about resident HR. Physician gave an order to writer to do a STAT CXR (chest x-ray) and metoprolol (beta-blocker medication) 12.5 BID (two times a day)… A nursing note dated [DATE] at 6:31 AM by RN “Q” read in part, “Resident spO2 [sic] decreased to 88%. Writer suctioned the resident trach (tracheostomy). Resident secretion has become thick. Resident spO2 is still remaining 88%. Writer informed Physician about the resident spO2. Writer was given an order ‘Duoneb (inhalation medication) q4 (every 4 hours) PRN (as needed)’… A nursing note dated [DATE] at 7:34 AM read in part, “Resident was unresponsive to verbal/physical/pain response. BS (blood sugar) was unreadable by glucometer, tachycardia (high heart rate), tachypneic (high respiratory rate) and diaphoretic (sweating). Physician was contacted but was unable to answer phone. Writer contacted DON who agreed an emergency transfer should be ordered. BP (blood pressure) 80/49 HR 131 RR (respiratory rate) 38 T (temperature 97.4 Spo2 86%” It should be noted, there were no progress notes found from any Medical Provider, from R175’s first admission or from the second admission on [DATE]. Review of R175’s vitals tab in the clinical record revealed documentation on [DATE] at 6:54 PM, when R175 was admitted , then no documentation until [DATE] at 7:45 AM when R175 was sent to the hospital. Review of R175’s discharge paperwork from the hospital dated [DATE] revealed R175’s admitting diagnosis was septic shock (the last and most severe stage of sepsis – immune system has an extreme reaction to an infection). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:07 PM, Nurse Practitioner (NP) “O” was interviewed and asked if she had seen R175. NP “O” explained she had at the hospital and at the facility. When asked about the lack of progress notes, NP “O” explained she was behind in writing notes. On [DATE] at 3:08 PM, the DON was interviewed and asked how often vitals should be done for a new admission. The DON explained they should be taken on admission and every shift. When informed of the lack of vitals for R175, the DON acknowledged the concern. The DON was asked how long had R175’s HR been elevated prior to the progress note on [DATE] at 11:33 PM, and if the HR had decreased or stayed the same until R175 was sent to the hospital on [DATE]. The DON asked to see if there was a SBAR Communication Form completed. Review of a SBAR document dated [DATE] at 8:28 AM revealed the only boxes with information were the boxes the electronic medical record system auto-populated by the system, including the vitals that were taken on [DATE] at 6:45 PM, three days prior. The DON explained without R175’s vitals documented, the lack of progress notes and an empty SBAR, it was hard to see what the story was. On [DATE] at 9:36 AM, Dr. “P”, R175’s attending physician, was interviewed by phone and asked about the lack of Medical Provider progress notes. Dr. “P” explained sometimes he was late in documenting. Dr. “P” was asked if he followed up after being call about R175 having a HR of 135 and he gave orders for a chest x-ray and Metoprolol. Dr. “P” explained he usually looked to see what was documented in the chart. When informed there were no vitals documented for R175, Dr. “P” had no answer. Dr. “P” explained residents were “sicker” when admitted now than they used to be in the past. Dr. “P” was asked if residents were sicker now, did not that require more monitoring. Dr. “P” had no answer. On [DATE] at 10:02 AM, RN “Q” was interviewed by phone and asked about R175 during her first admission. RN “Q” explained she worked the midnight shift on weekends and had R175 when she was first admitted on Friday [DATE], then when she came back on Saturday [DATE], R175 was different, her BS was elevated and her HR was high… called the doctor, who ordered an x-ray… was surprised it was negative for pneumonia, knew something was not right, then on Sunday [DATE] her breathing got worse. RN “Q” was asked if she took vitals as none were documented. RN “Q” explained she did, must not have put them in the computer. On [DATE] at 10:10 AM, LPN “R”, who was R175’s day shift nurse on [DATE] and [DATE], was interviewed by phone and asked if he had taken R175’s vitals. LPN “R” explained he “always” took vitals before giving medications. When informed there were no vitals documented for R175, LPN “R” had no answer. LPN “R” was asked if R175’s HR had been elevated. LPN “R” explained he thought her HR at baseline was a little elevated, like 90 to 100. When informed R175 had been sent to the hospital with Septic Shock, LPN “R” explained he never saw any symptom of Septic Shock, she had been stable. LPN “R” was asked if any Medical Provider had seen R175 on her first admission. LPN “R” explained usually there are no Medical Provider’s that come to the facility on the weekends. Review of a facility policy titled, “Notification of Changes” revised [DATE] read in part, “…Circumstances requiring notification include: 1. Accidents… 2. Significant change in the resident’s physical, mental, or psychosocial conditions such as deterioration in health, mental or psychosocial status… 3. Circumstances that require a need to alter treatment… 4. A transfer or discharge of the resident from the facility…”; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy that began on [DATE] was removed and the deficient practice corrected on [DATE] when the facility took the following actions to remove the immediacy. The facility assessed current residents for a change in condition by reviewing labs and vital signs. Education was provided to nursing staff on assessment, notifying the physician and implementing orders and documentation.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure timely interventions were implemented to prevent the development of two facility acquired pressure ulcers for one (R21) out of three residents reviewed for pressure sores/wounds. Findings include: On 8/12/25 at approximately 10:37 AM, R21 was observed lying in bed. Next to their bed was a pair of heel boot protectors. When asked why their boots were on the wheelchair, R21 reported that they are used for their heels that had sores and was waiting for staff to put them on as they no longer were able to do it on their own. They noted that they had been at the facility for several years and never had a problem with their heels, but a few months ago they started. R21 further noted that they believe they got the pressure ulcer because their heels were rubbing on the bed sheet.A review of R21's clinical record was conducted and revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Type II diabetes, generalized anxiety disorder and depression. A review of R21's Minimum Data Set (MDS) with a target date of 6/9/25 noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition) and was marked No for the questions Resident has a pressure ulcer/injury, a scar over bony prominence. In addition, it was marked No as to the resident at risk of developing the pressure ulcer and No as to whether the resident had one or more unhealed pressure ulcers.Continued review of R21's clinical record documented, the following:3/26/25: Physician Progress Note: .Has been having some intermittent L (left) heel pain on/off . *It should be noted that no interventions/orders for the left heel were put in following the physician visit.4/10/25: Order: Voltaren (arthritis pain relief- with a side effect noting may cause blisters) apply to left heel topically every shift for pain. *It should be noted that this order for pain relief was placed approximately 15 days after R21 complained of pain. 4/14/25: Skin Assessment: R21.Are there any new abnormal skin areas.Site: Left heel. Comments.DTI (deep tissue injury).soft, red and boggy, tender to touch.refer to wound care.4/17/25: Psychiatry Follow-up: .Patient seen in his room today with no signs of depression.anxiety. He has been having issues with his foot, as he appears he may have developed a blister.that may be a diabetic wound. The patient states he will see a wound care doctor on Monday but has not yet seen them.4/21/25: Skin and Wound Evaluation: [R21].Type: Blister.Location: Left heel.Acquired: In-house.Area: 4.3 cm (centimeter). Length 3.1 cm.Width 1.9.Notes: Resident prefers not to wear heel lift boots. *It should be noted that there was no documentation that indicated R21's heel boots were either ordered or refused.Care Plan: Focus: Resident has impaired skin integrity as evidenced by: Diabetes to Right heel, Blister to left heel.related to wearing shoes without socks.Date initiated 4/23/25.Revision on 8/5/25.Interventions: Administer medications as ordered (4/23/25).Encourage resident to reposition self if able.Pressure redistribution device in chair (4/23/25).Heel Protectors while in bed (8/12/25). *It should be noted that there was no orders for the Heel Protectors noted in R21's electronic medical record as of 8/13/25.4/19/25: Order: Wound care to eval and tx R/t ulcer of left heel.4/19/25: Order Administration: .Voltaren External Gel.Apply to L heel. Resident refused stating that the wound care nurse told him not to have it apply anymore.4/20/25: Charting: .L heel xray results reveals no fracture or osteomyelitis.:.5/12/25: Physician Progress Note: .initially admitted to the facility in November of 2021.EHR (electronic health record) notes patient is having left foot pain.with.a left foot decubitus ulcer.An X-ray has been done which did not show any fracture of osteomyelitis.6/19/25: NP/PA (nurse practitioner/physician assistant) Progress Note: .Per.patient is having left foot pain with left foot plantar fasciitis and a left foot decubitus ulcer.Patient seen in hallway.He states his wound is 'worse' because he was not offloading his heel properly in bed. He has pain when he tries to put pressure on his heel. 7/14/25: Alert Note: Skin and Wound- new wound identified via S & W (skin/wound) eval.Care plan up to date.7/21/25: Physician Progress Note: .Seen for eval (evaluation) heel ulcers now has changes over both heels.7/28/25: Skin Issues: .Location: left heel.type: Blister.Wound acquired in-house.painful.(. 92cm(centimeters)-length).(1.09 cm- width).(.2 cm-depth).#002: skin issue has been evaluated.Right heel. Diabetic foot ulcer.Length-2.53 (cm).Width 1.88(cm).2 area.3.74 undermining.slough 20%. Eschar 80% . 8/9/25: Pertinent Charting: .Site of infection: Right Heel.Reason for antibiotics.new signs and symptoms.On 8/14/25 at approximately 1:05 PM, an interview was conducted with Wound Care Nurse (WCN) NN. WCN NN reported they are a LPN (licensed practical nurse) and started as the wound care nurse at the facility in August 2024. WCN NN was asked as to the facility's protocol to prevent facility acquired pressure ulcers. WCN reported that new admits are assessed as to their potential for wounds. Skin assessments are then

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that catheter orders and monitoring were in place for one resident (R174) of one resident reviewed for catheter care resulting in the potential for infection and other complications. Findings include:On 8/12/25 at 9:43 AM, R174 was observed, lying in bed with foley Cather on ground and with no privacy bag. An attempt to interview R174 was made R174 was not verbal or able to understand questions.A review of the record revealed that R174 was readmitted to the facility on [DATE] with the medical diagnosis of Cognitive communication deficit, Alzheimer disease and dementia with a brief interview for mental status score (BIMs) that was skipped due to it not being conducted. A further review of the medical record indicated that there were no orders in place for a foley Cather nether was a care plan put into place. On 8/13/25 at 1:30 PM an interview was conducted with the Director of Nursing (DON), and asked what the protocol was with someone with a foley catheter. The DON reported that the resident should have a diagnosis, orders, privacy bag, stat lock (anchoring device), care plan and continuous monitoring. The DON was invited to observe R174. R174 was observed lying in bed with the foley catheter directly resting on the ground with no privacy bad. The DON then educated the nurse who was caring for R174 on the observed findings. The DON was asked did R174 have a diagnosis for a foley catheter, the DON reported they would have to check back.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain physician orders for two residents (R176 & R95) of three residents reviewed for respiratory care resulting in the potential for respiratory difficulties related to no orders for R176's Bi-level Positive Airway Pressure (BiPAP - a breathing aid/machine that helps people with breathing difficulties) and no orders for R95's tracheostomy care/speaking valve (a surgical procedure that creates an opening in the trachea/windpipe to allow for breathing and/or to remove secretions). Findings include: On 8/12/25 at 9:51 AM, R95 was observed in their room with their eyes closed, lying in bed with a tracheostomy(trach) which had a purple speaking valve to assist the resident with communication and speech. R95 was on room air (breathing on their own without supplemental oxygen), with suction and trach supplies set up near the bed. A review of the record revealed R95 was admitted to the facility on [DATE] with the medical diagnosis of Trach Status, Muscle weakness and cough with a Brief interview for mental status (BIMs) of 15 completed on 6/12/25 indicating no cognitive impairments. A further review of the record reveal that R95 did not have any orders to monitor, clean, or check the speaking valve. On 8/12/25 at 12:07PM, an interview with the Director of Nursing (DON) was conducted The DON was asked for the protocol with residents with a speaking valve, should there be monitoring order, cleaning orders and/or periods of rest noted? The DON explained that they would reach out to the corporate Respiratory therapist to clarify speaking valve orders/protocol. No additional information, was provided by the exit of survey. R176 Record review revealed R176 was admitted to the facility on [DATE] for skilled rehabilitation and nursing needs after hospitalization. R176’s admitting diagnoses included acute respiratory failure with hypoxia, Chronic Obstructive Pulmonary Disease (COPD), morbid obesity, diabetes and pulmonary embolism (blood clot in lungs). Based on the Brief Interview for Mental Status assessment (BIMS) dated 8/11/25, R176 had intact cognition. An initial observation was completed on 8/12/25 at approximately 9:25 AM. R176 was observed laying on their bed. They reported that they came over to the facility last Thursday from the hospital. They reported that they had been using a BiPAP machine at home for years and they also had one while they were at the hospital. They pointed to a machine that was on the nightstand on the left side of their bed and reported that the facility provided a CPAP ((Continuous Positive Airway Pressure machine that delivers the same pressure during both inhalation and exhalation) and they were unsure why they did not have the right machine (BIPAP). R176 also added that they were using the unit the facility had provided them with as they needed something to sleep. A follow up observation and interview was completed later that day at approximately 1:10 PM. During this interview R176 confirmed again their concern about not having the right breathing aid. They reported that they can feel the difference but they needed to use something so they could sleep. R176 also confirmed that they had not received any information from the nursing staff on the rationale. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R176’s hospital discharge summary revealed that R176 was admitted to the hospital with diagnosis of acute on chronic respiratory failure with hypoxia and hypercapnia, Obstructive Sleep Apnea (sleep disorder where breathing repeatedly stops and starts during sleep due to a blockage in airway) and was on BiPAP. Review of hospital discharge orders revealed a BiPAP order that read: BiPAP Set Rate-12 Breaths/min; IPAP (Inspiratory Positive Airway Pressure-18 CmH2O; EPAP/Expiratory Positive Airway Pressure)-5 CmH2O; Minute Ventilation:13.3 L/min. Review of facility admission orders did not reveal any orders for BiPAP and the admission care plans that did not reveal any care plan that R176 was receiving any BiPAP. Review of R176’s nursing admission progress notes from 8/7/25 did not reveal any documentation on BiPAP. A nursing progress note dated 8/13/25 at 2:13, read, “Resident CPAP (Continuous Positive Airway Pressure) is on….”. It must be noted that CPAP is a different breathing aid than BiPAP with no physician order. An interview with Registered Nurse (RN) “I” who was assigned to care for R176 was completed on 8/13/25 at approximately 8:35 AM. RN “I” was queried about the equipment that R176 had at their bed side. RN “I” confirmed that it was a CPAP (not BiPAP that was ordered at discharge) that R176 used at nighttime and they confirmed that there were no physician orders. They added the admitting nurse verified that residents had the right equipment and had placed those orders in the chart. They added that they would call the attending physician and obtain orders and would ensure that they had the right equipment and set-up. An interview with Unit Manager “V” was completed on 8/13/25 at approximately 8:55 AM. They were questioned about the process for obtaining physician orders for appropriate equipment that was ordered upon discharge from the hospital and how did they ensure that they had the appropriate set up as ordered by the physician. UM “V” added that the equipment was ordered through their vendor; the admitting nurses ensured the accuracy of the settings and unit manager would follow up after. They were queried about R176’s equipment and concerns with residents not having the right equipment and no physician order for the equipment they had at bedside. UM “V” reviewed the medical record and confirmed that R176 should have orders for BiPAP upon admission there were no orders and they were unsure of the equipment that R176 was currently using. They added they would call the attending physician and obtain an order and would add them to their care plan. UM “V” also confirmed that they did not have any respiratory therapist to ensure that R176 had the right equipment and set up. UM “V” was notified of the concerns and they reported that they understood the rationale for concern and they would follow up. An interview with the Director of Nursing (DON) was completed on 8/13/25 at approximately 4:15 PM. The DON was questioned about the process for obtaining physician orders for the equipment that was ordered and to ensure the accuracy of the settings. The DON reported that the equipment was ordered by their admissions coordinator based on the discharge orders from the hospital and the admitting nurse ensured the orders were in place as well as the accuracy of the equipment settings. They were notified of the concerns for R176 and they reported that they understood the concerns. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the facility administrator was completed on 8/13/25 at approximately 10:15 AM. During this interview the Regional Director of Operations (RDO) “DD” was present in the room. They were notified of the concerns of R176 not having the physician orders for BiPAP that was ordered upon discharge and nursing staff not following up to ensure the R176 had the right equipment with the right settings as ordered. Review of the facility provided document titled “Positive Airway Pressure (PAP) Therapy” with a revision date of 6/23/25 read in part, “Purpose: Positive Airway Pressure therapies have a wide range of applications in nursing home facilities. Health benefits of appropriately administered PAP therapy depend substantially on selection of the appropriate delivery device, input of accurate pressure level settings, correct application of delivery interface and equipment, and compliance from the user. It is imperative that knowledgeable and competent healthcare personnel are present in the setup, initiation, and monitoring of PAP therapies. Definitions: Continuous Positive Airway Pressure (CPAP) - One continuous pressure delivered and maintained throughout the respiratory cycle. Bi-level Positive Airway Pressure (BiPAP) - One level of positive pressure is delivered for inspiration, followed by a decrease to a second set pressure to allow for expiration. Average Volume Assured Pressure Support (AVAPs) - Provides a targeted tidal volume by automatically adjusting the inspiratory pressure support within a set range. Auto-adjusting Positive Airway Pressure (APAP) - Continuous delivery of pressure, with the delivered pressure fluctuating to meet the users ventilatory needs based on previous breaths taken. Procedure Explanation: Any method of PAP therapy administration must have an order in the residents EMR by a licensed provider to include the mode, pressure settings, liter flow of oxygen if applicable, and frequency of use. The respiratory therapist provides assistance to the residents in initiating therapy, ensuring the interface mask or pillows fit appropriately and comfortably and provide documentation in the residents EMR (electronic medical record). If a respiratory therapist is not assigned to the unit, therapy is only to be applied by knowledgeable and competent personnel…”.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1194668.Based on observation, interview, and record review, the facility failed to provide medically related social services related to discharge planning for one (R138) of one resident reviewed for social services. Findings include:Review of a complaint filed with the State Agency included allegations that R138 has expressed their desire to move to a different facility, but staff won't assist them with completing the transfer.On 8/12/2025 at 10:36 AM, R138 was observed lying in bed with oxygen via nasal cannula. When asked to review their concerns, R138 reported they have been wanting to go to another nursing home and have been asking social work staff for months, but nothing is being done. They further reported they were supposed to transfer to another nursing home and wanted to be back in the Detroit area and had a facility set up in March 2025, but they ended up being hospitalized around the time of transfer and instead of going to the new nursing home, they returned to the current facility. When asked what they have been told by the facility's social service staff, R138 stated they tell me they have spoken to different social service staff and are told they are looking into it but have had no follow-up.Review of the clinical record revealed R138 was admitted into the facility on [DATE], discharged on 3/6/25 and readmitted on [DATE] with diagnoses that included: chronic respiratory failure with hypoxia, morbid obesity due to excess calories, other pulmonary embolism without acute cor pulmonale, fracture of unspecified part of neck of right femur (3/13/25), contracture of muscle in right and left lower legs, unilateral primary osteoarthritis right knee, and repeated falls.According to the Minimum Data Set (MDS) assessment dated [DATE], R138 had intact cognition, had no behavior concerns, and did not have an active discharge plan to return to the community.According to the profile section of the electronic medical record (EMR), R138 was identified as their own responsible party for both financial and clinical needs.Review of the care plans included:Resident plans to discharge to Another SNF (Skilled Nursing Facility/Nursing Home) Clinic. This was initiated on 4/28/25. There were only two interventions which read, Coordinate care/discharge with new facility upon discharge (initiated 4/28/25), and Encourage resident/family/responsible party to participate in the discharge planning process. (initiated 4/28/25).Review of the social service progress notes revealed no documentation of what attempts had been completed to transfer R138 to another nursing home.Review of the social service assessments since March 2025 included:Social Service Progress Review - V 10 dated 6/9/25, locked 6/11/25 documented, .Things that make you become anxious/agitated: Being here .Has accepted placement .2. No .Describe .wants to transfer .Describe and indicate any interventions being used to address placement acceptance .Looking for relocation .Review of Discharge Plan .Looking to transferring to another SNF Clinic .Referral Status .none . Social Service Progress Review - V 10 dated 7/28/25 - locked 7/30/25 documented, .Things that make you become anxious/agitated .Being here in a facility .Has accepted placement .2. No .Describe .Wants to transfer .Review of Discharge Plan .LTC (long term care) until able to transfer .Referral Status .(blank) .On 8/13/25 at 11:45 AM, an interview was conducted with the Social Service Director (SSD ‘C') who reported they had been in their role since July 2024. SSD ‘C' further reported there have been several changes since the last recertification survey in the social service staff and they were currently the only licensed social worker. SSD ‘C' reported Social Service Assistant (Staff ‘D') had only been working at the facility for a short time.When asked if they were aware of R138's desire to transfer to another facility, SSD ‘C' reported they were. When asked what had been done to assist with this process, SSD ‘C' reported R138 was set up to transfer to the facility they wanted but it didn't work out. SSD ‘C' reported they attempted to transfer to other facilities but further reported the resident wanted a specific lift (this was not identified in the resident's clinical record - in progress notes, care plans, or social service assessments). SSD ‘C' reviewed the documentation available for R138 and confirmed there was no other details included as to what facilities had been attempted, or any other specifics details. SSD ‘C' reported they would follow-up with Staff ‘D', however there was no further follow-up or documentation provided by the end of the survey.According to the facility's policy titled, Discharge Planning Process dated 10/20/2023: .The facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge .The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community .The facility will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities .The facility will assist residents and their resident representatives in

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to properly store and secure medications and biologicals in one of eight medication carts and one of four medication rooms observed for medication storage. Findings include:On 8/14/25 at 12:32 PM, the Back Hall medication cart on the 1 North Unit was observed with LPN “L”. Upon opening the top left drawer, LPN “L” picked up a medicine cup of pills that was sitting in the drawer. The cup was not covered or labeled with a resident name. LPN “L” was asked what the medicine cup of pills was. LPN “L” explained she had prepared the medications for a resident, but they were not in their room, so she put it in the drawer to give them when they came back to the room. When asked who the resident was, LPN “L” explained she did not remember their name as she did not usually work that unit. A review of the stock medicine in the top left drawer revealed a bottle of Aspirin 81 milligrams (mg) that had a manufacturer expiration date of 1/2025. On 8/14/25 at 1:35 PM, the 1 North medication room was observed with LPN “M”. There were two small refrigerators one on top of the other. LPN “M” explained the top refrigerator was for the applesauce used for medication administration and protein supplements. In the door of the refrigerator was a clear plastic cup and straw that appeared to be iced coffee that still contained ice. When asked if the iced coffee was a residents’ or staff, LPN “M” explained she believed it was staff. In the bottom refrigerator medications were kept. A multidose vial of Aplisol (Tuberculin Purified Protein Derivative) had an open date of 5/28/25. When asked how long a multidose vial was good after opening, LPN “M” explained she did not know. On 8/14/25 at 2:05 PM, the Director of Nursing (DON) was interviewed and informed of the expired medications and the staff food in the medication room refrigerator. The DON explained there should never be any staff food in the medication room. Review of the manufacturer’s package insert for Aplisol dated 11/2013 read in part, “…Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency…” According to the facility's policy titled, Medication Storage dated 1/30/2024: .All drugs and biologicals will stored in locked compartments (i.e., medication carts, cabinets, drawers .Only authorized personnel will have access to the keys to locked compartments .Narcotics and Controlled Substances .Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key . On 8/12/2025 at 10:15 AM, during an observation of the facility’s secured memory care unit which had many residents ambulating and/or self-propelling in the hallway, the medication cart assigned to Nurse ‘F’ was observed unlocked. There was no nurse observed within the area that had direct supervision of the unsecured medication cart. A short time later, Nurse ‘F’ returned to the cart and stated, “Oh no, dang it, I thought I had locked the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/13/2025 at 8:06 AM, during an observation of the breakfast meal on the facility’s secured memory care unit, a medication cart was observed stored in the areas just outside of the dining room and was unlocked. The nurse assigned to that medication cart was Nurse ‘G’ and they were not observed to have direct supervision of the cart, they were administering medication to a resident who was eating breakfast in the dining room. A short time later, a Corporate staff was observed to walk by the cart and engage the locking mechanism. On 8/13/2025 at 8:09 AM, Nurse ‘G’ returned to the cart, unlocked it to obtain additional medication, then left the cart unlocked and proceeded to leave the area again. At that time, upon opening the top drawer of the unlocked medication cart, there was a small container of applesauce dated 8/12/25 and a gold watch stored in with the lancets used to obtain blood for blood sugar monitoring. On 8/13/25 at 8:11 AM, Nurse ‘G’ returned to the medication cart and was asked to complete a further observation of the contents of the cart. When asked about why the cart was left unlocked, Nurse ‘G’ reported “Oh, I forgot to lock it?”. They were informed of both observations and offered no further response. When asked about whether the applesauce should be stored in the top drawer of the medication cart, Nurse ‘G’ reported that was because this was a dementia unit and residents took stuff off the top of the cart. When asked the gold watch stored in and touching the lancets, Nurse ‘G’ removed the watch and placed in another area of the top drawer. When asked if any resident belongings should be stored in the medication cart, Nurse ‘G’ reported sometimes there was and sometimes things might also be kept in the narcotic box. Upon observation of the narcotic box, Nurse ‘G’ retrieved a black cell phone. When asked if they could identify who’s phone that was or who put it there, Nurse ‘G’ reported they were not sure. On 8/13/2025 at 8:15 AM, an interview was conducted with the Director of Nursing (DON). When asked if there should be any resident belongings stored in the medication carts, the DON stated, unless they have money they might store in lock box until able to give to administration. When asked if applesauce should be stored in the medication cart, they reported it should be a cooler with ice that's usually on top of the med cart. When asked if the medication carts should be locked when unsupervised, the DON reported they should always be locked when the Nure is not at the cart. The DON was informed of the multiple observations and reported they would have to follow-up.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure routine dental services were provided for one resident (R18) of one resident reviewed for ancillary services. Findings include:On 8/12/2025 at approximately 11:50 a.m., R18 was observed in their room, up in their wheelchair. R18 was observed to not have any teeth with their gum lines showing. R18 was queried if they have ever seen a dentist at the facility to examine their gums or to get dentures and they indicated they have not but would like dentures to be able to eat harder foods. On 8/13/25 at approximately 8:45 a.m., R18 was observed in their room, eating breakfast. R18 was queried regarding their ability to eat their soft breakfast, and they reported that they cannot eat anything hard because they have no teeth. On 8/13/25 the medical record for R18 was reviewed and revealed the following: R18 was initially admitted to the facility on [DATE] and had diagnoses including Dysphagia and Heart Failure. A review of R18's MDS (minimum data set) with an ARD (assessment reference date) of 5/20/25 revealed R18 needed supervision from facility staff with most of their activities of daily living. R18's BIMS score (brief interview of mental status) was 10 indicating moderately impaired cognition. A dietary note dated 4/8/25 revealed the following: Resident being seen for weight loss. Weight trend: 5.6%/8.6# x1 month and -10.4%/16.8# x6 months. Weight previously stable x5months. CBW (current body weight) 144.6# with BMI (body mass index) 29.2. Reviewed CBW/wt trend with resident- reports she has been consuming roughly two meals a day and that she does not wish to lose more weight. States she has been eating her chips and sodas. Observed chip stash and a bag of eaten chips at bedside.Resident had c/o (complaints of) pain on L (left) arm and did have x-ray 2/27/25 that revealed humeral fracture. Hospital records for evaluation showed dx (diagnosis) of bone contusion. Follow up x-ray on L arm was negative for fractures. Current diet order: Regular diet, Level 3 texture, Regular fluid, thin consistency- resident states she consumed pizza from outside the facility for lunch today. Referred to SLP (speech and language pathologist) for potential diet upgrade. Resident states she would also like to see if she can get dentures r/t (related to) she is edentulous (without teeth). Collaborated with social work. A Psychiatry evaluation dated 4/9/25 revealed the following: Abnormal weight loss *: Patient has experienced a 6 pound weight loss over 1 month (5% loss) and a 16 pound weight loss over 6 months (10% loss). Patient reports she is only accustomed to eating 2 meals a day instead of 3 but states she will try to increase to 3 meals daily after being notified of weight loss. Dietitian reports patient needs new dentures which is making eating difficult. Will monitor weight closely, consider dental evaluation for new dentures, and consider nutritional supplements if weight loss continues . A review of R18's routine dental consultations did not reveal any dental examinations/consults in their record since 3/5/22. On 8/13/25 at approximately 3:04 p.m., the facility Social Work Director C (SWD C) was queried regarding the lack of dental consults for R18 and R18's indications of wanting dentures in April 2025 due to their weight loss. They indicated they were unaware of the need of R18 to see the dentist would make sure they were seen on the next scheduled examination date. SWD C indicated they previously had some issues with dental services but did not know about R18's need for a referral to be seen for dentures.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews the facility failed to ensure meals were maintained and served at a palatable temperature affecting multiple residents, including multiple residents from the confidential group interview, resulting in dissatisfaction with meals and the potential for nutritional decline. Findings include: On 8/13/25 at approximately 2:30 PM, a Resident Council meeting was held with seven residents who asked to remain anonymous. Residents were asked about the food provided at the facility. One resident noted that they reside on the second floor and often food is served late and thus their food is cold. They noted that when they choose to eat in their room, they are always served last. Another resident reported that at times food is also cold when eating in the dining room. They noted that the facility may help residents get to the first-floor dining room at around 5:00 PM, but often they must wait until staff come and sometimes, they wait till almost 6:30 PM, resulting in cold food. Past Resident Council Minutes were reviewed and revealed the following: Date of Meeting: 4/7/25… New Business…Residents report that their breakfast is usually cold…”. Date of Meeting: 4/21/25…New Business…Residents report floor staff are stating they are not able to reheat food…When eating in the dining room residents report ice cream is served melted…”. “Date of Meeting: 6/2/25 .New Business…Meal served on 6/1/25 reported no steam coming from the steamtable…The BBQ Cheeseburger and fries were served cold in in the dining room on the 1st floor. Residents reported the meal was cold for room trays as well…”. “Date of Meeting: 7/7/25…New Business…Residents state lunch and dinner are served cold…”. On 8/13/25 at approximately 3:01 PM, an interview was conducted with Activity Director (AD) “EE” along with Corporate Activity Director (CAD) “FF”. AD “EE” reported they have been with the facility for about six weeks. CAD FF noted they started to fill in as the Activity Director in April 2025. When asked about the residents who reported concerns regarding cold food, they reported they were aware that residents had concerns regarding cold food. They noted that food was cooked to a correct temperature however, when staff did not serve food timely it resulted in cold food. On 8/14/2025 at approximately 12:50 PM an interview with the Administrator was conducted. When asked if they were aware of resident's concerns pertaining to cold food, they reported that they were new to the facility and were aware of the resident council notes pertaining to cold food. They noted that perhaps the minutes referred to old concerns but as they were new to the facility they could not confirm one way or another. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A temperature test for food palatability was completed with the Dietary Manager (DM) “LL” on 8/14/25. Lunch cart for 2-North unit arrived on the floor at approximately 1:05 PM. Nursing staff started passing the trays to residents’ rooms. DM “LL” arrived on the unit at approximately 1:20 PM, while staff were still passing the lunch trays. Temperature of the check on the test tray completed by DM “LL” revealed the following: The tray had regular meals that was served for lunch: Milk, Coffee, Juice/Fruit Punch, Pork, Cabbage, potatoes, and desert/pie. The food temperatures were as follows: Milk - 52.4 degrees Coffee – 121 degrees Juice – 61.8 degrees Dessert/Cream pie - 54 – icing on the pie appeared melty and was soft/mushy Cabbage - 121 Pork – 102.3 degrees Potatoes – 102.1 degrees An interview was completed with DM “LL” after the temperature test and queried why the food temperatures were not meeting the requirements and resident concern about cold food from multiple residents. DM “LL” reported they were using plate warmers, and they were unsure why they food temperatures were not meeting their requirements, and they would look into their process. [NAME] also added that sometimes the staff were busy, and the trays were not served timely. They were notified that for the staff started serving approximately 5 minutes after the cart arrived today. They reported that they understood the concern.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review facility failed to maintain food service equipment based on professional standards for food service safety resulting in the potential to result in food borne illness among all residents who consume food/drinks from the kitchen. Findings include:An initial kitchen tour was completed on 8/12/25 at approximately 8:50 AM with the Dietary Manager (DM) LL. The ice machine filter cover in the kitchen appeared brown in color. The ice machine filter did not have any date labels on the filter. DM LL was questioned about their process for ice machine cleaning and maintenance. They reported that the facility utilized an outside vendor for cleaning and the unit was cleaned two weeks ago. When queried about the color and further documentation, DM LL reported that the records were maintained by the facility's maintenance department. They were requested to provide the cleaning/maintenance records after their last annual/re-certification survey to the current date. They were not sure why the ice machine filter had no service dates. The ice machine had a service sticker with handwritten service data with the following information:The sticker read Ice Machine Maintenance Log and had the following dates: 5/13/24; 8/22/24; 7/30/24; 1/26/24 and 3/3/23.A request for ice machine service/filter change documentation was requested to the facility administrator. The facility provided additional documentation revealed ice machine service/filter change records dated 5/22/24 and 1/26/24 (approximately over 15 months ago). There were no other records for any routine inspection, cleaning and filter change between these two periods.A review of the latest correspondence sent to the facility administration in December-2024 by the County's Environmental Health Epidemiologist recommended to follow the control measures as part of the facility's Water Management Plan (WMP) and to ensure that facility's water management team is implementing the facility's WMP. Review of facility's WMP book revealed the section titled Operation, Maintenance, and Control Limits. The sub-section for routine maintenance, monitoring, and cleaning for ice machine revealed a plan that included:Daily - Visual monitoringMonthly - Cleaning/De-scaling; Filter inspectionDuring a follow up interview with DM LL on 8/14/25 at approximately 9:50 AM, they were notified of the concern with the routine maintenance and cleaning of the ice machine. They reported that they understood the concern. When queried about the process and their expectations, UM LL reported that they expected to clean and change filters at least every 3-6 months and they were unsure of the facility policy. They added that the facility maintenance director was completing the checks and scheduling filter changes.An interview with Maintenance Director MM was completed on 8/14/25 at approximately 12:20 PM. They reported that they had been at this since September-2024 and added that they were not sure how often the facility was doing the monitoring and filter changes prior. Maintenance Director MM was notified of the concern, and they reported that they understood and added that were going to start doing the monitoring quarterly.An interview with the facility administrator was completed on 8/14/25 at approximately 4:15 PM. During this interview Regional Director of Operations (RDO) DD was present in the office. They were notified of the concerns with routine monitoring and maintenance of ice machines. The administrator reported that they understood the concern and did not have any further explanation.A facility provided document titled Ice Storage with a revision date 7/1/25 did not reveal any specific monitoring and maintenance protocols. It read Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions and maintains a copy of these guidelines. No additional guidelines for maintenance were provided prior to the survey exit.According to the 2022 FDA Food Code Section 5-205.15 System Maintained in Good Repair, A plumbing system shall be: (A) Repaired according to law; P and(B) Maintained in good repair. According to Food Code Section 4-602.13 Nonfood-Contact Surfaces. Nonfood-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility failed to identify area of deficiency and maintain an effective quality assurance and performance improvement program (QAPI) for respiratory care, catheter care and residents experiencing changes in condition. This practice has the potential to affect all residents that reside in the facility. Findings include:On 8/15/25 at approximately 11:12 a.m., a review of the facility's QAPI program was conducted with the facility Administrator. The Administrator reported they have only been the Administrator for a few weeks but was aware there were some areas of concern regarding the QA program. The Administrator was queried what action plans the facility had been working on to maintain sustained compliance and reported that a few areas of concern that they had identified were respiratory and catheter care. The Administrator was queried what interventions they had in place to maintain compliance for catheter care and they indicated they were doing audits and reviewing Physican orders. The Administrator was queried what was being done to address respiratory care and they reported they had been working on ensuring tracheostomy care was being done correctly. At that time, the Administrator was queried regarding the concerns the survey team had identified during the survey including catheter care and respiratory care and they indicated that they would have to review their process. The Administrator was queried regarding the survey teams concerns regarding identifying compliance issues potentially related to resident deaths and hospitalizations and they reported they did not identify concerns with those areas as the Director of Nursing and been reviewing deaths and hospitalizations. The Administrator indicated that they were working to immediately correct the survey teams identified deficiencies in those areas. Cross-Reference tags F684, F690 and F695. On 8/15/25 a facility document titled QAPI plan was reviewed and revealed the following: Purpose: It is the policy of this facility to systematically collect data as part of the QAPI program to ensure the care and services it delivers meet acceptable standards of quality in accordance with recognized standards of practice. In addition, the purpose of this document is to serve as a plan to assist the facility in development, implementation, and maintenance of an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The goal is to create a process that ensures care and services delivered meet accepted standards of quality. The QAPI plan is supported by multiple, specific policies and procedures to support the facility in the above stated purpose. Key components of this plan may include but are not limited to 1. Tracking and measuring performance. 2. Establishing goals and thresholds for performance improvements. 3 Identifying and prioritizing quality deficiencies 4. Systematically analyzing underlying causes of systemic quality deficiencies.5. Developing and implementing corrective action or performance improvement activities. 6. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. Prioritization of program activities that focus on high-risk, high-volume, or problem- prone areas as identified in the facility assessment that reflects the specific units, programs, departments and unique population the facility serves. Explanation and Compliance Guidelines: 1. Data will be collected from all departments, residents, and family members. a. Sources of data include, but are not limited to varying for situational awareness: i. The facility assessment ii . Paper and electronic medical records iii. Stand up meeting data collection/ stand down meeting follow up iv. Grievance logs v. Medical record audits and drug regimen reviews vi. Skilled care claims vii. Clinical logs such as for falls, pressure injuries, and weights (including SOC meetings) viii. Staffing trends ix. Incident and accident reports, including reports of adverse events or abuse, neglect, or exploitation (Risk Management, FRI/SRI (Reportable events) Log) x. Minimum Data Set (MDS) (Carewatch data sets) xi. Quality measures (QM report)/ 5 Star Reports xii. Survey outcomes/ Plan of Correction Support Calls/ QCR results xiii. Staff, resident, and family satisfaction surveys (Resident Voice 72, 7 day and Discharge survey as well as the entire caring partners program. Caring partners data in the Power BI System) xiv. Suggestions from staff, residents and families- given formally or informally in care conferences, at staff meetings or shift to shift huddles. xv. Trigger calls man xvi. DON Weekly Report xvii. Facility Dashboard Review xviii. Return to Hospital Report/Review xix. Infection control binder basics audits xx. Dietary Quick Rounds/ Monthly Sanitation Audits xxi. Resident Council Minutes xxii. Family Council Minutes xxiii, Safety Committee Meeting/ Outcomes xxiv. Compliance Line Calls xxv. Business Development Workbook xxvi. Health Care Source reports (Recruitment/Retention/ Applicant flow reports) xxvii. New Hire/Turnover reports xxviii. DSO (Days Sale Outstanding)/Cash Report/ Medicaid Pending/LOCD Logs XXIX. Pharmacy Scorecard/ Pharmacist review xxx. TELs compliance report (Preventative maintenance/ work orders) xxxi. Triple Check

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure proper infection control protocols and practices for implementation of enhanced barrier precautions (EBP) and transmission-based precautions (TBP) for two (R5 and R10) of three residents reviewed for infection control. This deficient practice has the likelihood to result in cross-contamination and the spread of infection and disease. Findings include:R10 Record review revealed R10 was admitted to the facility on [DATE] for skilled nursing and rehabilitation services after hospitalization. R10’s admitting diagnoses included sepsis, Urinary Tract Infection (UTI) complicated, with Extended Spectrum Beta-Lactamase resistance (ESBL) (ESBLs are enzymes that specifically target and degrade certain antibiotics, rendering them ineffective), history of viral hepatitis, reduced mobility and weakness. An initial observation was completed on 8/12/25 at approximately 10:20 AM. R10 was observed in their bed. R10’s door had a signage that read “Enhanced Barrier Precautions” and the door had a holder with Personal Protective Equipment (PPE – gown, mask, and gloves). Based on definition from Centers for Disease Control and Prevention (CDC) EBPs are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) that involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). Review of R10’s Electronic Medical Record (EMR) revealed dated 7/23/25 that read, “Use enhanced barriers while performing high-contact activity with the resident related to ESBL (extended sprctrum betalactamase) every shift”. Further review revealed that R10 was still receiving antibiotics for their infection diagnosed during the hospital stay. An order dated 7/23/25 read “Fosfomycin Tromethamine Oral Packet 3 GM (gram) (Fosfomycin Tromethamine) Give 1 packet by mouth one time a day every Fri for ESBL for 30 Days”. Review of discharge orders from hospital in the hospital transfer form dated 7/23/25 read in part, “Place patient in contact isolation for E. coli ESBL positive in urine…”. Based on definition from CDC contact isolation/precautions are described as specific measures taken to prevent the transmission of infectious agents that are spread by direct or indirect contact with the resident or their environment. Contact precautions require healthcare personnel to wear gowns and gloves every time they enter a resident's room. Contact precautions are implemented for residents with known infections that can be transmitted through contact. Review of facility’s internal admission communication memo included with the hospital referral had resident admission details (diagnosis, admission date/time, room number, physician etc.) and had “contact isolation: ESBL in urine”. During the follow up observation completed on 8/13/25 at approximately 8:35 AM, R10 was observed in their bed. Room door had the same signed that read “Enhanced Barrier Precautions”. (continued on next page)

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	235296	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Southfield	26715 Greenfield Rd Southfield, MI 48076

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Registered Nurse (RN) “I” was completed on 8/13/25 at approximately 8:45 AM. They were queried about the signage on the door and why. RN “I” reported that R10 had UTI (urinary tract infection), and it was colonized (Colonization means bacteria are present and growing on or inside a person/animal without causing any noticeable illness or harm) and that is why R10 was on EBP. When RN “I” was queried about the current antibiotics that R10 was on and the discharge orders from the hospital, RN “I” reported that R10 should have been contact precautions not EBP and they got this resident confused with another resident. They added they would let the Infection Preventionist know. An interview with the facility’s infection preventionist (IPC) “GG” was completed on 8/13/25 at approximately 11:35 AM. They reported that they recently accepted the Infection Preventionist role on an interim basis. They were queried about R10 and the current orders for antibiotics and discharge orders from the hospital and why this resident was on EBP and not on contact precautions. IPC “GG” reviewed the EMR and reported that R10 should have been on contact precautions, not EBP. IPC “GG” was notified of the concern and agreed and reported that they would update the orders, care plan, and change the signage on the R10’s room door. At approximately 12:45 PM, the signage on R10’s room door read “CONTACT PRECAUTIONS”. Two staff members from the therapy department were observed entering into R10’s room with no PPE and the door was closed. A few minutes later they were observed when the door was opened, and they exited the room, which was brought to the attention of the unit manager (UM) “V” who were in the hallway outside R10’s room. UM “V” was notified of the concern, and they reported that all staff should be following the precautions as ordered. An interview with the Director of Nursing (DON) was completed on 8/13/25 at approximately 4:25 PM. They were notified of the concerns. DON reported that their team would review the discharge records from hospital and would make a decision for appropriate precautions. They added that IPC “GG” was covering in the current role on an interim basis and might have received guidance from other team members. When queried about staff expectations for PPE use, the DON reported that they were notified by the nursing team about staff members not using appropriate PPE and they understood the concerns. On 8/14/25 at approximately 4:25 PM, the facility administrator and Regional Director of Operations (RDO) “GG” were notified of the concerns. The administrator reported that they were aware of the concerns and they did not have any questions. A facility provided document titled “Infection Prevention and Control Program” with a revision date of 12/27/23 read in part, “Policy: this facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Definitions: “Staff” includes facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facilities nursing aid training programs or from affiliated academic institutions. Policy Explanation and Guidelines: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record revealed R5 was admitted into the facility on 8/21/24 and readmitted on [DATE] with diagnoses that included: type 2 diabetes mellitus with other specified complication, Alzheimer's disease with late onset, paranoid schizophrenia, other encephalopathy, and arterial ulcer. According to the MDS assessment dated [DATE], R8 had BIMS 9/15, had no venous or pressure ulcers but is at risk. Further review of the progress notes included: An entry on 8/11/25 at 6:53 AM read: “Skin Issues: Skin Issue: #001: Skin issue has been evaluated. Location: Right Dorsum 2nd Digit (Second toe). Issue type: Arterial. Progress: Stable: previously deteriorating wound characteristics plateaued. Wound acquired in-house. It is unknown how long the wound has been present….Staged by: In-house nursing. Length (cm) (Centimeter): 0.54 Width (cm): 0.73 Depth (cm): 0.2 Area (cm2) (cubic centimeter): 0.31 Undermining: No. Tunneling: No. Epithelial: 20%. Granulation: 80%. Slough: 0%. Eschar: 0%. Exudate amount: Moderate. Exudate type: Serous: clear watery fluid, which is separated from solid elements. Odor after cleansing: None. Other: pink or red. Periwound: Attached. Surrounding tissue: Maceration. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Moderate 26-75%. Cleansing solution: Generic wound cleanser. Primary dressing: Calcium alginate. Secondary dressing: Dry. Modalities: None. Additional care: Incontinence management. Additional care: Turning / repositioning program. Additional care: Moisture barrier. Additional care: Mattress with pump.Skin Issues Note: Wound is stable. Treatment is Calcium Alginate, Dry Dressing.Skin issue education: Turn every 2 hours. Skin issue education: Change / shift positions frequently. Skin issue education: Moisture barrier. Skin issue notification: Guardian. Skin issue notification: Provider.” Review of the current physician orders included: Cleanse with wound cleanser. Pat dry. Apply Calcium Alginate as directed to Right Dorsum 2 nd Digit (Toe). Cover with Dry Dressing every day shift for wound care AND as needed for wound care. This order started on 8/12/25. (There were previous wound care orders in place prior to this order.) Use enhanced barriers while performing high-contact activity with the resident. For wound every shift. This order started on 2/13/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/25 at 11:25 AM, an interview was conducted with the current Infection Preventionist (IP ‘A’). They reported they were in their role as Interim IP since about 6/20/25. When asked to explain how the facility implemented EBP and determined who was on and what should be done, IP ‘A’ reported they usually discussed that in team meetings and coordinated with the wound care nurse to identify which resident has wounds and reported anyone with wounds would require EBP. When asked about R5's wounds, they reported they received information from the wound care nurse it was resolved and they thought it was the end of last week. When informed of the concerns that R5 was observed with wound care treatment since 8/12, has current orders for EBP and wound care notes with measurements of current wounds, IP ‘A’ reported if the resident no longer had wounds, the wound care nurse would change the order to discontinue EBP. When asked what would be implemented for a resident that was on EBP, IP ‘A’ stated there would be signage on the door, an orange dot by their name, gowns, gloves and hand sanitizer that’s to be used on the walls and all nursing carts. IP ‘A’ was informed of the observations of lack of EBP use and knowledge from staff of R5 being on EBP and they reported they would have to follow-up. There was no additional information provided by the end of the survey. On 8/14/25 at 11:56 AM, further review of the physician orders included: Use enhanced barriers while performing high-contact activity with the resident r/t (related to) wound. every shift. Active start date 8/13/25. According to the facility's policy titled, Enhanced Barrier Precautions (EBP) dated 3/26/2024: .Initiation of Enhanced Barrier Precautions .an order for enhanced barrier precautions will be obtained for residents with any of the following .wounds (e.g., chronic wounds such as pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers .Indwelling medical devices .Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply .Implementation of Enhanced Barrier Precautions may include but is not limited to .Make gowns and gloves readily available near or outside of the resident's room .Position a trash can for discarding PPE after removal, prior to exiting the room or before providing care to another resident in the same room .High-contact resident care activities to consider include .Dressing .Providing personal hygiene .Changing briefs or assisting with toileting .