STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235312	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Of	725 West Fuller Big Rapids, MI 49307

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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F 0580 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 interview and record reviews the facility failed to notify the responsible party of changes in conditions and treatment for one Resident (R5) of fifteen residents reviewed. Findings Resident #5 (R5) Review of the Electronic Medical Record (EMR) reflected R5 admitted to the facility 3/11/2018 with diagnoses that included: Traumatic Brain Dysfunction, Aphasia (inability or difficulty speaking), and Hemiplegia (weakness or paralysis on one side). Review of the Minimum Data Set (MDS) dated [DATE] reflected R5 was severely cognitively impaired. The EMR admission Record reflected Primary Contact (PC) K was the Guardian for R5. On 7/16/2025 at 11:16 AM a telephone interview was conducted with PC K who reported the facility had not always informed her of changes in status and care for R5. PC K reported several months ago she contacted the facility for an update on R5. PC K reported staff informed her R5 had been sick. PC K reported she contacted the facility a day or two later and was told by the facility R5 had pneumonia and was started on an antibiotic. PC K reported if she did not call the facility she would not have been aware of the condition or treatment of R5. PC K indicated she was not consistently informed of other alterations in status and the care of R5 over time. A review of the EMR was conducted: Review of the Progress Note documented 9/3/2024 reflected R5's blood sugars were evaluated by a Physician Assistant (PA) who implemented a new medication order for Januvia. The documentation did not reflect PC K had been informed of the results of the evaluation and the new medication. Review of the EMR Progress Note of 10/4/2024 reflected a PA again evaluated R5's blood sugars and implemented a medication change. The entry did not reflect PC K was informed of the change. The Progress Note of 10/29/2025 at 2:00 PM reflected R5 was catheterized to obtain a urine specimen that was sent to the lab. The entry did not reflect PC K had been informed of any concerns. Review of the Progress Note dated 11/27/2024 at 10:50 AM reflected R5 presented with a change of respiratory condition and direction to obtain a chest Xray, administer an antibiotic and initiate regular breathing treatments. The entry did not reflect PC K had been notified. The Progress Note dated 12/3/2024 at 11:18 AM reflected a Gradual Dose Reduction (GDR) of a psychotropic medication being conducted. No documentation was identified in the EMR that indicated PC K was aware of this. The Pharmacy Progress Note of 1/28/2025 at 5:55 PM reflected a new order for Norvasc (a medication used in treatment for high blood pressure) had been implemented. No documentation in the EMR was identified that PC K had been informed. Review of the Progress Notes revealed a Dietary Note dated 4/16/2025 at 2:28 PM that reflected R5 was being followed for weight loss over the past month. This and no previous entries were identified that PC K had been informed R5 had experienced a weight loss. The EMR Progress Note dated 4/18/2025 at 9:28 AM revealed a Psychiatry Follow up encounter by a PA. The entry noted the GDR of the psychotropic medication in December of 2024, and that this medication had been discontinued the day of this entry. The documentation reflected facility staff were to discuss the plan of care with the resident's responsible party. However, no documentation was identified in the EMR that reflected PC K was aware of the GDR or the discontinuation of the medication. An EMR Progress Note entry on 6/15/2025 at 12:23 AM reflected R5 had an open area on his penis and an ointment was being applied as a remedy. Neither this entry nor other surrounding documentation was identified that indicated PC K was notified R5 had an open area of skin. On 7/17/2025 at 12:51 PM an interview was conducted with the Director of Nursing (DON). The DON was informed that the Guardian for R5 reported not being informed of changes in the status and plan of care of the Resident over time. The DON was informed that a review of the EMR supported this assertion as documentation was not identified that the Guardian had been notified of changes in condition and treatment for R5. The DON indicated a review would be conducted. As of survey exit no information had been provided by the facility that the Guardian had been informed of the matters noted above.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident care plans were reviewed, revised, and implemented for 2 of 15 residents (Resident #40 and #5) reviewed for care plans. Findings: Resident #40 (R40) Review of an admission Record revealed R40 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Muscular Dystrophy and dysphagia (difficulty swallowing). Review of R40’s “Antigravity Team Note” dated 6/12/25 revealed, “Date of Fall: 6/11/25Root Cause(s) of Fall: Rolled from bed…New Interventions: Floor mats added…” Review of R40’s fall “Care Plan” on 7/16/25 at 12:09 PM and on 7/17/25 at 11:02 AM revealed, “I am at an increased risk for falls r/t (related to) muscular dystrophy, muscle weakness, DM II (diabetes type 2), depression, anxiety, chronic pain, scoliosis, history of falls. Date Initiated: 11/23/2023. ” There was no intervention for the placement of a floor mat. During an interview on 07/18/2025 at 8:30 AM, Staff Development Coordinator (SDC) “G” reported that R40’s “Care Plans” should reflect her current status and preferences and she would follow up. Review of R40’s fall “Care Plan” on 7/18/25 at 11:15 AM revealed, “…Fall mats at bedside due to risk of rolling from bed.” Review of R40’s nutrition “Care Plan” revealed, “I have the potential for a nutritional/hydration problem r/t DM (diabetes mellitus), CKD (chronic kidney disease), dysphagia, depression, HLD (hyperlipidemia), risk for malnutrition Date Initiated: 12/06/2023…Patient to eat in dining room only, or by nurses' station for supervision. Date Initiated: 11/16/2024…” During an observation and interview on 07/16/2025 at 8:44 AM, R40 was observed eating her breakfast in bed without supervision. R40 reported that she would routinely eat her breakfast and dinner in her bed without supervision. Additionally, there was a fall mat in her room leaning up against the wall. It was not positioned next to the bed. During an observation on 07/17/2025 at 8:49 AM, R40 was observed eating her breakfast in bed without supervision. There was a fall mat in her room leaning up against the wall not positioned next to the bed. During an observation on 07/17/2025 at 10:59 AM, R40 was in bed resting with her eyes closed. There was a fall mat in her room leaning up against the wall not positioned next to the bed. Resident #5 (R5) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Electronic Medical Record (EMR) reflected R5 admitted to the facility 3/11/2018 with pertinent diagnoses that included: Traumatic Brain Dysfunction, Aphasia (inability or difficulty speaking), and Cognitive Communication Deficit. Review of the Minimum Data Set (MDS) dated [DATE] reflected R5 was significantly cognitively impaired. On 7/17/2025 at 11:09 AM Certified Nurse Aide (CNA) “J” reported she had worked at the facility for several years and frequently provided care to R5. CNA “J” reported she often cannot figure out what R5 wants. CNA “J” reported that R5 will point but that she cannot understand the Resident. Review of the Care Plan for R5 revealed a “Focus” of “I have a communication problem (related to) previous traumatic brain injury; my speech may sound garbled at times. I have a communication board. Please encourage me to use it and write out my words” initiated 2/27/2019. The documented “Goal” of this Care Plan was “I will be able to make basic needs known by physical communication on a daily basis…” initiated 2/27/2019. “Interventions” included: “Help me develop a communication tool that I can utilize to communicate my needs” and “Monitor/document frustration level. Allow me time before providing me with words” initiated 2/27/2019. Further review of the Care Plan reflected no new interventions since 2/10/2020. No monitoring documentation or tool was identified in the EMR for the Care Plan intervention of “Monitor/document frustration level” of R5. On 7/17/2025 at 12:51 PM the communication difficulties identified for R5 were discussed with the Director of Nursing (DON). The DON reported a review would be conducted. On 7/17/2025 at 1:30 PM the room of R5 was reviewed. No communication board was found. R5 shook his head “No” when asked if he had a communication board and if he knew what this was.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow professional standards of nursing practice for 2 of 15 residents (Resident #40 and #55) reviewed for medication administration. Findings:Resident #40 (R40) Review of an admission Record revealed R40 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Muscular Dystrophy and dysphagia (difficulty swallowing). The diagnosis of dysphagia was added to her diagnosis list on 12/1/23. Review of R40’s “Care Plan” revealed no entries that R40 could self-administer medications. Review of R40’s “Self-Administration of Medication Evaluation” revealed the assessment for self-administering medications was last completed on 8/10/23 (prior to the dysphagia diagnosis). Review of R40’s “SLP (Speech Language Pathology) Screen” dated 11/27/23 revealed R40 did not have the physical capacity to swallow without difficulty and had difficult/painful swallowing and would cough/choke with meals/medications. During an observation and interview on 07/16/2025 at 8:44 AM, a medication cup full of medications was observed on R40’s tray table next to her breakfast tray. R40 reported that staff “always leave them here” further explaining that she prefers to take them on her own time. R40 reported that she was hospitalized and diagnosed with dysphagia around Thanksgiving of 2023 which resulted in a change of her diet to prevent her from aspirating/choking. During an interview on 07/17/2025 at 2:30 PM, Nursing Home Administrator (NHA) reported that R40 did not self-administer medication and therefore did not have a recent “Self-Administration of Medication Evaluation.” During an interview on 07/18/2025 at 8:30 AM, Staff Development Coordinator (SDC) “G” reported that medications were not to be left on R40’s tray table and licensed nurses were to observe R40 take her medications due to the safety risks present from her dysphagia diagnosis. Review of the facility policy “Resident Rights” last reviewed/revised February 2025 revealed, “…f. The right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate…” Review of the facility policy “Medication Administration” implemented 2/9/25 revealed, “…18. Observe resident consumption of medication…” Resident #55 (R55) Review of the medical record reflected R55 admitted to the facility 6/13/2025 with pertinent diagnoses that included Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) Section C (cognitive patterns) reflected R15 was cognitively intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/2025 at 8:21 AM an observation, interview, and record review were conducted with Registered Nurse (RN) “L” at the medication cart on the Southeast Hall. RN “L” was observed preparing the morning medication for R55. During this preparation the Medication Administration Record (MAR) was reviewed as RN “L” selected each medication ordered to be administered. The medications reviewed included “Breztri Aerosphere Inhalation Aerosol (a handheld multidose inhaler) 160-9-4.8 MCG/CT 2 puff inhale orally two times a day for COPD” with the direction to “Rinse mouth thoroughly and expectorate after using”. The observation of the medication administration at the above date and time continued. Once prepared, RN “L” carried the medications to the room of R55 who was sitting in a chair eating breakfast. R55 took the medication cup of oral medications from RN “L” and self-administered these without difficulty. RN “L” then handed the Breztri Aerosphere inhaler to R55 who self-administrated two puffs. R55 then handed the Breztri Aerosphere inhaler back to RN “L” and resumed eating breakfast. RN “L” exited the room. On return to the medication cart RN “L” was asked if he should have had R55 rinse her mouth and spit out the water following the self-administration of the Breztri Aerosphere inhaler? RN “L” stated “I’d have to look that up”. This statement indicated the direction on the MAR for this inhaler had not been noted by RN “L”. RN “L” did not re-review the MAR or provide any further clarification of proper use of the Breztri Aerosphere inhaler. A review of the EMR Doctor’s Order of the Breztri Aerosphere confirmed the direction on the MAR to “Rinse mouth thoroughly and expectorate after using”. Review of the manufacturer’s product information sheet/ package insert for the Breztri Aerosphere Inhaler reflected, “Warnings and Precautions”, Candida albicans infection of the mouth and pharynx may occur (a pathogenic overgrowth of a yeast-like fungus that lines the digestive tract). Monitor Patients periodically. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk”. Review of the facility policy “Medication Administration” implemented 2/9/2025 revealed, “Policy: Medications are administered by licensed nurses or competent medication technicians as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection”. And “12 a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects”. And “17. Administer medication as ordered in accordance with manufacturer specifications”. And “24. Refer to pharmacy manual for specific medication-related policies and procedures”.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to 1.) ensure insulin was administered and monitored following the provider order and 2.) ensure abnormal blood sugar results were reported to the provider for 3 of 15 residents (Resident #40, #10, and #64) reviewed for insulin administration.Findings:Resident #40 (R40) Review of an admission Record revealed R40 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Muscular Dystrophy Review of R40's Order Summary dated 5/3/25 revealed, HumaLOG KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject 4 unit subcutaneously with meals for DM2 In addition to sliding scale insulin. Hold if BS <100 (blood sugar less than 100) or not eating.Review of R40's June Medication Administration Record and Blood Sugar Summary revealed that on 6/24/2025 at 08:06 AM R40's blood sugar was 93 and the 4 units of Humalog was administered. (The sliding scale insulin was not administered due to her blood sugar not falling within range.)Review of R40's July Medication Administration Record and Blood Sugar Summary revealed that on 7/12/2025 at 09:31 AM R40's blood sugar was 94 and the 4 units of Humalog was administered. (The sliding scale insulin was not administered due to her blood sugar not falling within range.)Review of R40's Electronic Medical Record revealed no documentation for the rationale for administering the insulin outside of the ordered parameters. Resident #10 (R10) Review of an admission Record revealed R10 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Type 1 Diabetes. Review of R10's Order Summary dated 4/4/25 revealed, Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro).Call MD (medical doctor) for BS (blood sugar) greater than 500. before meals and at bedtime. To be administered and blood sugars assessed at 8:00 AM, 12:00 PM, 4:00 Pm, and 8:00 PM.Review of R10's Blood Sugar Summary revealed:*On 7/1/2025 at 9:09 PM R10's blood sugar was 525*On 7/3/2025 at 11:12 PM R10's blood sugar was 520*On 7/9/2025 at 4:35 PM R10's blood sugar was 547*On 7/11/2025 at 11:06 PM R10's blood sugar was 553*On 7/15/2025 at 08:55 AM R10's blood sugar was 501*On 7/15/2025 at 10:56 PM R10's blood sugar was 519*On 7/17/2025 at 8:36 AM R10's blood sugar was 524 Review of R10's Electronic Medical Record revealed no documentation that the provider was notified of the blood sugars listed above. During an interview via email on 07/17/2025 at 2:30 PM, Nursing Home Administrator (NHA) reported that the facility provider is notified with high blood sugars no new orders, because (R10 is a) brittle diabetic. During an interview on 07/17/2025 at 9:57 AM, Director of Nursing reported there was no documentation that the provider was notified of the abnormal blood sugar results or that a new order was received. Resident #64 (R64) Review of an admission Record revealed R64 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: type 2 diabetes. Review of R64's Order Summary dated 7/10/25 revealed, QAM (every morning) blood sugar checks for DM2 (type 2 diabetes) one time a day.Review of R64's Blood Sugar Summary on 7/18/25 at 11:30 AM revealed R64's blood sugar was NOT assessed on 7/13/25, 7/14/25, 7/15/25, 7/16/25, or 7/18/25.Review of R64's July Medication Administration Record revealed a check mark for each day (from 7/10/25-7/18/25) indicating the blood sugar assessment had been completed. Review of R64's Electronic Medical Record revealed no documentation that a blood sugar assessment had been completed or a rationale for not obtaining the blood sugar. During an interview on 07/18/2025 at 8:30 AM, Staff Development Coordinator (SDC) G reported that the expectation was for the licensed nurses to follow the physicians orders including the ordered parameters. Review of the facility policy Medication Administration implemented 2/9/25 revealed, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.10. Ensure that the six rights of medication administration are followed.

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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. Based on observation, interview, and record review, the facility failed to ensure proper care of a Continuous Positive Airway Pressure (CPAP) device for one Resident (R15) of fifteen residents reviewed. Findings: Resident #15 (R15) Review of the medical record reflected R15 admitted to the facility 10/21/2019 with the pertinent diagnosis of Obstructive Sleep Apnea (a condition when breathing stops while sleeping due to a blockage of the windpipe). The medical record reflected that R15 used a CPAP device (the device that consisted of a pressure module that delivered breathable air under pressure via tubing from the device to a mask worn while sleeping to keep the windpipe open) to treat this condition. On 7/16/2025 at 10:09 AM an observation and interview were conducted with R15 in her room. It was observed that R15 had a CPAP device that was not in use and the mask was not stored in a bag. Review of the CPAP filter revealed it was moderately soiled. R15 reported that staff had not cleaned her CPAP in a long time. On 7/17/2025 at 10:53 AM during an observation and interview with R15 in her room it was noted that her CPAP device was not in use and that the mask was not stored in a bag. R15 reported staff had given her a bag a couple of years ago and told her to use it. R15 displayed a folded plastic bag and reported that the current bag was the same bag provided by the facility a couple of years ago. R15 reported that staff did not check daily for proper storage of the mask when not in use and reiterated that staff do not clean her device. Review of the filter revealed that it had not been cleaned or changed and remained moderately soiled as noted on 7/16/2025. Review of the Medication Administration Record (MAR) for July 2025 and the Treatment Administration Record (TAR) for July 2025 did not reflect maintenance of the CPAP device for R15 monitored by Nursing. Review of the Tasks in the EMR for the previous thirty days reflected documentation that staff had cleaned R15's CPAP mask once or twice a day. Additionally, the documentation in tasks reflected the filter was to be changed or cleaned weekly and as needed. The documentation alleged that the filter had last been cleaned or changed on 7/14/2025, two days before the first observation when the filter was noted to be moderately soiled. The policy provided by the facility titled BIPAP-CPAP implemented 11/2009 was reviewed. The policy reflected Procedure: h. Store mask or nasal pillows in mesh bag or other approved storage container approved by the facility when not in use. The policy continued with 5. Cleaning: a. Mask or nasal pillows shall be wiped with an approved disinfecting solution daily per manufacturer's guidelines. And e. Replace mesh bag (or other approved storage device) monthly. And f. Filters cleaned weekly per manufacturer's recommendation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 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 interview and record review, the facility failed to ensure controlled medications were properly dispensed and documented for 3 of 15 residents (Residents #2, #4, and #25) reviewed for controlled medication administration. Findings:Resident #2 (R2) Review of an admission Record revealed R2 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: osteoporosis. Review of R2's Order Summary dated 5/26/25 revealed, tramadol HCl Oral Tablet 50 MG Give 1 tablet by mouth two times a day for PAIN.Review of R2's Controlled Substance Proof-Of-Use Record revealed that on 7/1/25, 7/2/25, 7/3/25, and 7/14/25 the evening doses of tramadol were documented as dispensed.Review of R2's July Medication Administration Record revealed that on 7/1/25, 7/2/25, 7/3/25, and 7/14/25 the evening doses of tramadol were documented as not administered. Review of R2's Controlled Substance Proof-Of-Use Record revealed that on 7/4/25 there were no doses of tramadol documented as dispensed. Review of R2's July Medication Administration Record revealed that on 7/4/25 the morning dose of tramadol was documented as administered. Review of R2's Electronic Medical Record revealed no documentation as to why the medication was dispensed but not administered. During an interview on 07/17/2025 at 9:57 AM, Director of Nursing (DON) provided a written statement dated 7/16/25 which revealed that the primary nurse for R2 removed the tramadol from the medication cart and wasted (disposed of) the tramadol and a secondary nurse witnessed the waste. DON confirmed the documentation error for the tramadol administration on 7/4/25.Resident #4 (R4) Review of an admission Record revealed R4 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety disorder. Review of R4's Order Summary with a start date of 3/19/25 and an end date of 4/2/25 revealed, Alprazolam (Xanax) Tablet 0.25 MG Give 0.25 mg by mouth every 6 hours as needed for Agitation for 14 Days.Review of R4's Controlled Substance Proof-Of-Use Record revealed that on 4/10/25 a dose of Xanax was dispensed (without an active order).Review of R4's April Medication Administration Record revealed no documentation that a dose of Xanax was administered. Review of R4's Electronic Medical Record revealed no documentation for the administration of Xanax without a physician order. During an interview on 07/17/2025 at 9:57 AM, DON reported that the provider had given a 1-time verbal order for the use of Xanax, however, the licensed nurse did not transcribe the order into the Electronic Health Record or document the one-time order in the progress notes. Resident #25 (R25) Review of an admission Record revealed R25 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety disorder. Review of R25's Order Summary dated 7/8/25 revealed, Lorazepam Oral Tablet 0.5 MG (Ativan) Give 1 tablet by mouth every 4 hours as needed for anxiety for 14 Days.Review of R25's Controlled Substance Proof-Of-Use Record revealed:*On 7/14/25 at 4:23 PM a dose of Ativan was dispensed. *On 7/14/25 at 7:01 PM a dose of Ativan was dispensed.*On 7/15/25 at 9:30 AM a dose of Ativan was dispensed.Review of R25's July Medication Administration Record revealed no documentation that the dose of Ativan was administered on 7/14/25 at 7:01 PM or on 7/15/25 at 9:30 AM.Review of R25's Electronic Medical Record revealed no documentation related to the administration of Ativan on 7/14/25 at 7:01 PM or on 7/15/25 at 9:30 AM.During an interview on 07/17/2025 at 9:57 AM, DON confirmed the licensed nurses had not documented the administration of Ativan into the Medication Administration Record.Review of the facility policy Controlled Substances dated June 2019 revealed, .D. Accurate accountability of the inventory of all controlled substances is maintained at all times. When a controlled substance is administered, the nurse administering the medication immediately enters the following information on the controlled substance count sheet and on the Medication Administration Record (MAR):1) Date and time of administration (MAR, controlled substance count sheet)2) Amount administered (controlled substance count sheet)3) Remaining quantity (controlled substance count sheet)4) Initials of the nurse administering the dose (MAR, controlled substance count sheet)E. When a dose of a controlled substance is removed from the container but refused by the resident or not given for any reason, it is not placed back in the container; it must be destroyed according to facility policy, and the disposal must be documented on the controlled substance count sheet on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents (R52 and R60) observed during the medication administration task, resulting in a medication error rate of 6.66% (2 errors of 30 medications administered).Findings include:R52A review of R52's admission Record, dated 7/18/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R52's admission Record revealed multiple diagnoses that included Vitamin D deficiency.During an observation on 7/16/25 at 8:25 AM, Licensed Practical Nurse (LPN) E administered eleven medications to R52, including Vitamin D3 (cholecalciferol) 50 mcg (micrograms) (2000 International Units (IU)).A review of R52's Medication Administration Record (MAR), dated 7/1/25 to 7/18/25, revealed LPN E should have administered cholecalciferol 1000 units on 7/16/25, not cholecalciferol 2000 units.During an interview on 7/16/25 at 12:18 PM, the Director of Nursing (DON) was notified of the medication error. R60A review of R60's admission Record, dated 7/17/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R60's admission Record revealed multiple diagnoses that included chronic pain syndrome, back spasm, and neuropathy (nerve damage that can cause symptoms such as pain, weakness, numbness, or tingling).During an observation on 07/15/2025 at 4:35 PM, Registered Nurse (RN) F stated R60's morphine sulfate medication order had been changed earlier in the day. RN F then verbalized the dose they were giving to R60 and administered 40 milligrams (mg) of morphine sulfate oral solution (2 milliliters (ml) of morphine sulfate 20mg/ml) to R60. During an interview on 07/16/2025 at 11:19 AM, RN D stated she just administered 40 mg of morphine sulfate oral solution to R60 for her 11:30 AM dose. A review of R60's MAR, dated 7/1/25 to 7/16/25, revealed RN D and RN F should have administered morphine sulfate 20 mg to R60, not 40 mg. A review of R60's Controlled Substance Proof-Of-Use Record, dated 7/13/25 to 7/16/25, revealed R60 had also received 40 mg of morphine sulfate oral solution on 7/16/25 at 4:54 AM. During an interview on 07/16/2025 at 11:15 AM, the DON was notified of medication errors with R60. The DON stated he would investigate the errors. During a second interview on 07/16/2025 at 3:00 PM, the DON stated he investigated the medication errors and agreed that R60 receiving 40 mg (2 ml) of morphine was an error. The DON reported he had contacted the physician and hospice provider, and both providers acknowledged the errors in morphine dosing, A review of the facility's Medication Administration policy and procedure, dated 2/9/25, revealed, 10. Ensure that the six rights of medication administration are followed. c. Right dosage. 11. Review MAR to identify medication to be administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to properly label medications in 1 of 2 medication carts (Northeast/ Northwest Split Medication Cart) observed for medication storage.Findings include: During an observation on 07/16/2025 at 8:35 AM, the Northeast/Northwest Split Medication Cart was inspected with Licensed Practical Nurse (LPN) E. The following observations were made: - Incruse Ellipta 62.5 mcg/act discus box labeled with R52's name. However, the discus in the box was not labeled with R52's name and/or any other resident identifying information. - Fluticasone propionate 50 mcg/act nasal spray box labeled with R52's name. However, the nasal spray was not labeled with R52's name and/or any other resident identifying information. During an interview on 07/16/2025 following the inspection of the Northeast/Northwest Split Medication Cart at 8:35 AM, LPN E stated, They (the discus and nasal spray) should be labeled [with the resident's name] so we know if they are in the right box. LPN E also stated the discus, and nasal spray should be labeled with the resident's name, so staff know who the discus and nasal spray belong to in case they fall out of their respective boxes, During an interview on 07/16/2025 at 9:55 AM, Registered Nurse (RN) D stated that staff should label discuses and nasal sprays in the boxes with the residents' names. She stated they do this so we know we're giving the right med (medication) to the right patient (resident). RN D also stated the discuses, and nasal sprays should be labeled with the resident's name in case they fall out of their respective boxes, so staff know who the discus and inhaler belong to.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for 3 of 15 sampled residents (R3, R51, and R69). Findings include:Resident #51 (R51) A review of R51’s admission Record, dated 07/17/2025, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R51 had multiple diagnoses that included depression, bipolar disease, schizophrenia, and alcohol-induced disorder. R51’s admission Record also revealed they were their own responsible party (in charge of their own medical decisions). A review of R51’s Order Summary Report, dated 7/17/25, revealed R51 had physician orders for Benztropine Mesylate (a medication for Parkinson’s Disease and movement disorders from other diseases or side effects from antipsychotic medications) 0.5 milligrams (mg) twice a day and Bupropion (a medication for depression) 150 mg once a day. In addition, R51’s Order Summary Report revealed R51 was also prescribed Fluphenazine decanoate (an antipsychotic medication for bipolar disease) and Olanzepine (an antipsychotic medication for bipolar disease). A review of R51’s medical record, dated 06/25/2025 to 07/17/2025, failed to reveal any documentation that R51 was made aware in advance of the risks and benefits of a medication, the treatment alternatives or other options and was able to choose the option he preferred prior to the facility administering Benztropine Mesylate and Bupropion to him. During an interview on 07/17/2025 at 10:36 AM, the Director of Nursing (DON) stated R51's psychotropic medications are managed by CMH (Community of Mental Health- an outside agency). The DON stated he would contact them and get something from them to put into R51's medical record documenting that R51 was aware in advance of the risks and benefits of Benztropine Mesylate and Bupropion, the treatment alternatives or other options, and he was able to choose the option he preferred when he was admitted to the facility. During a second interview on 07/17/2025 at 11:30 AM, the DON stated the facility received R51's consent for psychoactive medications (including Benztropine Mesylate and Bupropion) from CMH. The DON stated the facility had done consents (including risks versus benefits of use and the treatment alternatives or other options) for antipsychotic medications (Fluphenazine decanoate and Olanzepine) when R51 had been admitted to the facility. However, the facility did not have any documentation that they had completed any consents for Benztropine Mesylate and Bupropion. Resident # 69 (R69) A review of R69’s admission Record, dated 07/18/2025, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R69’s admission Record revealed they had multiple diagnoses including cervical spinal stenosis, osteoarthritis, and encounter for other orthopedic aftercare. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R69’s Discharge Instructions and Recap of Stay form, dated 05/14/2025, revealed that R69 had been admitted to the facility following an elective spinal surgery, progressed well, and was ready for discharge home on [DATE]. However, the “Nursing Services- Recap of Stay- Brief summary of medical stay” revealed, “This resident is in need for skilled services that can only be provided in SNF (Skilled Nursing Facility) on a daily basis for Encounter for Other Orthopedic Aftercare. I estimate the length of stay needed is 14 days.” This statement implied that R69 still needed skilled services that only the facility could provide when she discharged home after only 3 days at the facility. In addition, this statement appeared to be a reason for R69’s admission to the facility and not a summary of their stay. During an interview on 07/17/2025 at 4:00 PM, the DON stated it appeared the nurse manager copied and pasted the information from the hospital discharge summary into her section of R69’s Discharge Instructions and Recap of Stay form. The DON stated he was fine with that since that was the reason that R69 was at the facility. When the DON was informed that the nursing recap of stay at the facility was a summary of what occurred while the resident was at the facility and should be a summary of the resident’s stay and not just the reason for their admission he agreed, but stated he was fine with the nurse manager copying and pasting information from the hospital records into R69’s “Nursing Services- Recap of Stay” section of the Discharge Instructions and Recap of Stay form and did not see anything wrong with her (the nurse manager’s) documentation. During an interview on 07/18/2025 at 9:15 AM, Clinical Care Coordinator (CCC) “C” stated she had been R69’s nurse manager while she (R69) had been at the facility. CCC “C” also stated that she had filled out the “Nursing Services- Recap of Stay” section on R69’s Discharge Instructions and Recap of Stay form. CCC “C” was asked if she copied and pasted her note from any other documentation or if she typed it herself. CCC “C” stated she copied it and pasted it from R69’s “Order Recap Report” (not from R69’s hospital records) under the “Order” tab in R69’s medical record and showed the surveyor that she copied it from the physician order, dated 05/12/2025. CCC “C” stated, “I always copy and paste this (the admission physician order) into the nursing re-cap of stay section of a resident's discharge paperwork. That was what I was trained to do. “Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice… Documentation of nurses’ work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing’s contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care… High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings… Patient documentation frequently is used by professionals who are not directly involved with the patient’s care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient’s care to use the documentation. (ANA’s (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www. nursingworld.org/globalassest/docs/ana/ethics/principles -of-nursing-documentation.pdf, retrieved on 07/22/2025). Resident #3 (R3) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Electronic Medical Record (EMR) reflected R3 admitted to the facility 8/23/2023 with diagnoses that included Quadriplegia (unable to use arms and legs). The EMR reflected R3 was cognitively intact and was able to make his own medical decisions. Review of the EMR Progress Note entry of 6/18/2025 at 12:43 PM reflected that R3 was transported to the hospital when a change of condition was identified. The entry did not reflect that pertinent information about the Resident’s condition was conveyed to the receiving hospital. The entry did not reflect that R3 was provided information on the facility bed hold policy. On 7/17/2025 at 3:46 PM an interview was conducted with the Director of Nursing (DON). The DON reported that when a resident was transferred to the hospital an “Interact” transfer form was completed and contains the documentation of contact with the hospital to convey pertinent resident information and documentation regarding the bed hold policy. The DON reported a review would be conducted for the information for the 6/18/25 event for R3.Review of the EMR index of Interact transfer forms did not reveal this form had been completed for R3 on 6/18/2025 On 7/18/2025 at 10:11 AM the DON acknowledged that an Interact transfer form for R3 on 6/18/25 was not completed and entered into the medical record. This indicated that the medical record did not contain complete documentation to verify that the hospital had been contacted with information pertinent to the change of condition of R3. Additionally, no documentation was included regarding the bed hold policy. urther review of the EMR Progress Notes revealed a “late entry” had been entered on 7/17/25 at 4:01 PM and placed in the Progress Notes time slot for 6/18/25 at 3:49 PM. The entry reflected the hospital had been notified that R3 was “enroute” and the reason for the transfer. The late entry documentation did not include information regarding the bed hold policy.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1239234:Based on observation, interview, and record review, the facility failed to ensure a clean environment for 2 residents (R7 and R17) reviewed for environmental concerns. Findings include: On 7/11/2025 the Long-Term Care Ombudsman reported that the facility was odoriferous (unpleasant smell) during recent visits. On 7/15/2025 at 11:04 AM a strong smell of urine was noted at and around the Nurse's Station at the South East/West Hall becoming more pronounced down the hall past room [ROOM NUMBER] and continued to room [ROOM NUMBER] before subsiding but still notable. Due to the strong prevalence of the odor in the area the source could not immediately be isolated. Resident #7 (R7) Review of the medical record reflected R7 admitted to the facility 5/3/2024 with pertinent diagnoses that included Need for Assistance with Personal Care. Review of the Minimum Data Set (MDS) dated [DATE] reflected R7 was occasionally incontinent of urine and was not on a toileting program. The Care Plan for R7 reflected the Resident was safe for self-transfers and was ambulatory with a walker. On 7/17/2025 at 11:02 AM an observation and interview were conducted with Certified Nurse Aide (CNA) J in room [ROOM NUMBER] the room of R7. CNA J was asked about the strong smell of urine in the hallway and in room [ROOM NUMBER]. CNA J reported that R7, who resides in bed one, can toilet himself but has trouble urinating into the toilet due to vision problems. CNA J reported R7 urinates on and around the toilet all the time and it was not unusual for the floor around the toilet to be wet with urine. CNA J reported she often checks the bathroom of R7 when she first comes on shift and will contact Housekeeping to ask the urine to be mopped up. Resident #17 (R17) Review of the medical record reflected R17 admitted to the facility with pertinent diagnoses that included Diabetes Mellitus and Benign Prostatic Hyperplasia (enlarged prostate). Review of the Kardex (a summary of the resident's needs and preferences) reflected that R17 was independent for toileting and used a urinal at bedside. On 7/15/2025 at 11:46 AM an observation was conducted in room [ROOM NUMBER] where R17 resided in bed 2. At the head of the bed of R17 two urinals were observed on a towel on the floor. One urinal was full and standing up and the other urinal was empty and laying down. The room had a strong smell of urine as did the hall prior to entering the room. On 7/15/2025 at 1:35 PM, in the room of R17 it was observed that the full urinal remained unemptied and neither urinal had been repositioned on the floor by the bed. On 7/16/2025 at 11:27 AM, in the room of R17 two urinals were observed on the floor at the head of the bed. Both urinals were standing upright. One was completely full, and the other was roughly half filled with urine. A half-filled urinal was observed also hanging but the handle from the wastebasket at bed one. A noticeable urine smell was present in the room. On 7/17/2025 at 10:49 AM, R17 was observed to be asleep in bed two of his room. Two urinals were noted on floor at the head of the bed. One urinal was standing on end half full of urine and the other laying empty on its side. At bed one urinal half-filled urine was hanging on a waste basket half full. The smell of urine was evident in the room. Review of the Resident Council Meeting Minutes dated 2/3/2025 revealed, .Toilets need to be cleaned better after dumping bed pans or urinals.Review of the Resident Council Meeting Minutes dated 4/1/2025 revealed, .Dumping of bed pans/urinals is getting careless and messy.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews.Findings:Review of the Facility Assessment dated 8/6/24 revealed, .INFORMATION ABOUT OUR STAFF TRAINING/EDUCATION AND COMPETENCIES-Our facility's training program includes an orientation process and ongoing training for all new and existing staff including managers, nursing and other direct care staff, individuals providing services under contractual arrangement, and volunteers consistent with their expected roles. We complete an education needs assessment and develop a curriculum and training plan based on staff need (sic) and resident characteristics.Review of Certified Nursing Assistant (CNA) I's employee file revealed she was hired on 12/18/2023. There were no performance evaluations completed since CNA I's date of hire. Review of CNA I's computerized education/continuing competencies hours revealed:*On 12/30/23, Employee Safety Orientation was completed for 1 hour of education. *On 1/3/24, Code of Conduct was completed but did not count for education hours. No other education was completed until 1/9/25.Review of CNA H's employee file revealed she was hired 10/17/2022. There were no performance evaluations completed for 2023 or 2024.During an interview on 07/18/2025 at 8:58 AM, Nursing Home Administrator (NHA) reported that performance evaluations had not been done in 2024 due to the HR (Human Resources) department putting it on hold in order to streamline the process. NHA reported he was unsure if they had been completed in 2023 as he was not the acting administrator at the time. NHA reported that yearly education was completed by computerized training program, bi-monthly meetings, and the yearly skills assessment/in-service. NHA reported any concerns brought to the attention of management via resident council, staff complaints, or surveys were addressed in the bimonthly meetings with education provided.