STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235331	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Howell	1333 W Grand River Howell, MI 48843

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement fall interventions for three residents (R2, R17, R68) of twelve residents reviewed for falls/accidents resulting in R2 sustaining bruising, swelling, and pain to mid back region of the head, and decline in previous independent ADL's (Activities of Daily Living). Findings include:R68 On 12/9/25 at approximately 11:35 AM, R68 was observed sitting in their wheelchair. The resident had swelling and bruising on their right hand. When asked as to what happened to their hand they reported that they had a fall. R68 who was alert, reported that they had pushed their call light, waited a very long time and then tried to get up on their own and fell. A review of R68's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Congestive Heart Failure and Type II Diabetes. A review of R68's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (intact cognition) and was noted as their own responsible person. A request for IAs (incident/accident) reports was made. The following were provided: 11/9/25 (5:20 AM) Other: .Resident (R68).Nursing Description: resident was self-transferring and hit head on her bed.Predisposing Situational Factors:.ambulating without assistance.Recent Room Change.Notes: IDT (interdisciplinary team) reviewed.while self-transferring resident's head made contact with her bed.re-educated to use call light when needing assistance. (Authored by Nurse X). It should be noted that an attempt to contact Nurse X was made on 12/11/25 at approximately 1:25 PM, a voice message was left. No return call was received prior to the end of the Survey. 11/9/25 (1:00 PM): Unwitnessed Fall: Resident (R68).Nursing Description:. screaming help writer entered residents room and resident is sitting on the floor with one arm on the wheelchair seat and another on the bed.resident scooted to the floor and saying she does not want to get up.root cause analysis.Resident with recent room move, resident note to have an increase in negative and attention seeking behaviors since room move.Intervention: resident re-educated on using call light when needing assistance. (Authored by Nurse U) *It should be noted that Nurse U was no longer employed by the facility at the time of Survey. An attempt to contact them was made on 12/11/25 at approximately 11:43 AM. 11/10/25 (9:50AM): Unwitnessed Fall: Resident (R68).Nursing Description: was called into residents room by CNA (certified nursing assistant) who reported resident was on the floor.resident laying on the floor oxygen tubing not in nose.Immediate Action Taken: full set of vitals taken resident has an elevated BP (blood pressure) along with hr (heart rate), resident was sent to Hospital.resident was (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	sent to hospital for further evaluation post fall. 11/17/25: Fall Risk Evaluation: .Resident (R68).Interventions Required.Mobility: unable to transfer on and off toilet, bed, or chair safely.Unsafe behaviors: Attempts to stand, transfer and/or walk independently when they require assistance.History of falls: .Yes.comments: blank. 11/19/25 (6:00 AM): Unwitnessed Fall: Resident (R68).Nursing Description: resident found on the floor lying on her back.resident has bruising on both knees and her right hand has swollen up.resident asked what happened and she said she just rolled out of bed on to the floor. *An IDT (interdisciplinary team) note accompanied the IA that documented: .Root Cause was determined to be related to recent room move and more recent bed move.(Authored by Nurse X). It should be noted that an attempt to contact Nurse X was made on 12/11/25 at approximately 1:25 PM, a voice message was left. No return call was received prior to the end of the Survey. Fall assessments were also reviewed and revealed the following: 11/9/25: Fall-Initial: Resident (R68).Date of fall 11/9/25.what was resident doing prior to fall: Sitting in wheelchair.Plan of Care Review: New Interventions:.Other.educated on using call light for assistance. *It should be noted that the IA does not document the resident was sitting in their wheelchair prior to fall and the intervention to use a call light was documented in the care plan prior to this incident. 11/10/25: Fall-Initial: Resident (R68).Date of fall 11/10/25.what was resident doing prior to the fall: sitting in wheelchair.Describe pain: jaw and neck.Describe other interventions: Dycem (non-slip pad) to wheelchair. *It should be noted that the IA does not document the resident was sitting in their wheelchair prior to fall and the intervention for a Dycem was documented as an intervention prior to this incident. 11/11/25: Fall-Initial: Resident (68).Date of fall: 11/11/25.What was resident doing prior to fall: resident was being assisted to toilet.New Interventions: BLANK. 11/19/25: Fall-Initial: Resident (68).Date of fall: 11/19/25.What was resident doing prior to fall.What was resident doing prior to fall: Resident was in bed. Plan of Care Review: Assist bar put on bed. *It should be noted that R68's care plan noted an assist bar was in place as an intervention prior to this incident. On 12/11/25 at approximately 2:00 PM, an interview and record review were conducted with the Director of Nursing (DON). The DON reported they were new to the facility and not very familiar with R68. The DON was asked to review the falls that occurred and the interventions that were put in to reduce the numerous falls. The DON reviewed the care plan and confirmed that the Dysem and assist bars were already in place. The DON noted that they would speak with the ADON (Assistant Director of Nursing) to see if there was any additional information put into place. No additional information was provided prior to the end of the Survey. R2 Clinical record review revealed R2 was admitted to the facility on [DATE]and had a history of weakness, and chronic pain, cardiovascular disease and dementia. A Brief Interview of Mental Status (BIMS) assessed on 11/25/25 scored 13/15 indicating R2 had no cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Clinical record review of a progress note and investigation report authored by Licensed Practical Nurse (LPN) K documented on 11/16/25 at 11:55 PM, R2 was heard yelling for help. Upon entering their room, R2 was observed sitting on the floor next to their bed. R2 stated they reached for their rolling walker (RW), it moved, and they landed on their buttocks and hit their head. R2 initially did not remember the name of the facility, was assessed having a newly bruised bump on their mid back of head, with pain and discomfort rated three out of ten and described as .tender to touch. On 12/11/25 at 8:40 LPN L was contacted by phone for an interview, and no response was received by the close of this investigation. On 12/11/25 at 9:49 AM, a telephone interview with former Nurse Unit Manager (NUM) confirmed R2 was independent, would dress, toilet and feed themself and was compliant asking for help if needed. After R2 fell on [DATE], NUM M remarked a decline in all previous activities. R2 required staff assist with dressing, transfers, ambulating, toileting and at times feeding. NUM M said when R2 started asking for help, they knew something was not right because R2 was known to tell staff they .could do it themself. and was observed previously doing such things independently. Review of Pertinent Charting-Change in Condition from 11/18/25 at 8:32 documented: .Change identified: S/P <sic>fall resident has exhibited need for 1 person assisted d/t <sic> functional debilitation. Review of Pertinent Charting-Change in Condition from 11/19/25 at 01:20 documented: .Weakness and unsteady gait noted since fall. Review of Pertinent Charting-Change in Condition from 11/19/25 at 11:39 documented: .Resident was not able to communicate.change in condition after a fall that happened earlier in the week. Review of Pertinent Charting-Change in Condition from 11/19/25 at 14:20 documented: .Decline in transfers after fall Resident had wet bed this am which resident is usually continent.resident unable to assess pain.needed assistance with lunch. Review of Pertinent Charting-Pain from 11/20/25 at 03:07 documented: .sore at times.Lump remains back of head. Review of Pertinent Charting-Change in Condition from 11/20/25 at 03:09 documented: .Lethargic and decline in care.Continues to need increased help from staff. On 12/11/25 at 11:52 AM, a telephone interview with LPN J acknowledged prior to the fall on 11/16/25 R2 was for the most part independent with ambulating and ADL's (Activities of Daily Living) and therefore documented the following as this was a change since the fall. Record review of a Progress note dated 11/19/25 authored by LPN J documented: .Originally identified change: Weakness and unsteady gait noted since fall. Record review of the Investigation Summary post fall documented .New Intervention(s) implemented post-fall.Equipment modification.RW (Roller walker) locks not locking. and a work order was submitted for repair. On 12/11/25 at 8:58 AM, the Director of Maintenance (DOM) I confirmed their department was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	responsible for repairing all equipment at the facility including residents' adaptive equipment which included walkers, rolling walkers, and wheelchairs. On 12/11/25 at 9:15 AM, DOM I was asked to show what was repaired on R2's rolling walker. Upon entrance, R2 was observed asleep and unavailable for an interview. The rolling walker was next to their bed and DOM I pointed and commented the silver-colored fastener between the locks and brake cable tends to loosen after time and use. When asked if there was a schedule for preventative maintenance for the resident's equipment, DOM I replied unfortunately there was not but that is probably a good idea. DOM I provided a copy of the work order #24341 created on 11/17/25 at 3:13 AM and documented .fell because of faulty locks. R17 On 12/09/2025 at approximately 10:15 a.m., R17 was observed in the hallway dining room, sitting in an armchair with his legs up on the wheelchair seat. R17 was observed to have large facial bruising and a blood shot eye. R17 was queried how they obtained the bruising on their face and they were unable to say what happened. On 12/10/25 at approximately 9:22 a.m., R17 was observed in their room, sleeping in their bed. R17's side of the room was observed to be dark without any lighting on. R17's wheelchair was observed to not contain a cushion or any dycem (a non-slip material to prevent sliding) and was observed to be unlocked. On 12/11/25 at approximately 9:05 a.m., R17 was observed in the common area/dining room. R17 was sitting in an armchair, without any shoes on. R17 had one missing anti-rollback bar from their wheelchair and no dycem was observed in the seat. On 12/11/25 at approximately 10:20 a.m., R17 was observed with Nurse R and Nurse R was shown R17's wheelchair missing the anti-roll back bar and dycem along with R17 not having any shoes with bare feet. Nurse R was queried if R17 was at risk for falling and needed their interventions of dycem, footwear and anti-rollback bar and they reported they were and they would have to let staff know to come and give them some shoes and place some dycem on the wheelchair along with replacing the anti-rollback bar on the back of the chair. On 12/10/25 the medical record for R17 was reviewed and revealed the following: R17 was initially admitted to the facility on [DATE] and had diagnoses including Dementia, Repeated Falls and Restless and Agitation. A review of R17's comprehensive plan of care revealed the following: Focus- Resident is at risk for falls/injury related to: potential seizure activity, history of falling, takes psychotropic medication, and cognitive deficits Resident often chooses to self-transfer from bed to wheelchair, or wheelchair to bed, often being observed as plopping self onto bed or into wheelchair Date Initiated: 04/22/2024 .Interventions-Keep an over the bed light on at night. Date Initiated: 12/27/2024, Midnight staff to get resident up before end of the shift, as resident allows. Date Initiated: 06/13/2025, nonskid socks, frequent monitoring by staff. Date Initiated: 09/11/2025, Dycem to wheelchair Date Initiated: 08/16/2025, Ensure the resident's room is free from accident hazards (e.g., providing adequate lighting, ensuring there are no trip hazards, providing assistive devices) Date Initiated: 04/22/2024 . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/11/25 at approximately 11:00 a.m., during a conversation with Nurse Manager T (NM T), NM T was queried regarding the fall interventions that were not in place per R17's care plan and they reported that R17 was a fall risk and that the interventions noted in the care plan should be in place such as the dycem being on the wheelchair, overhead light on when in bed sleeping, the wheelchair being locked at the bedside and the anti-rollback bar being replaced.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to incident #2667744.Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for four (R60, R74, R142 and R186) of nine residents reviewed for abuse. Findings include: R186 and R74 On 12/9/25 at approximately 10:43 AM, R186 was observed sitting in a reclining chair. R186 was alert and reported that they had been at the facility for a few weeks and this was the third or fourth room they were in. The resident had a large bruise on the left forearm along with several bloody scabs and scratches. When asked what happened, they replied that their roommate hit them. They stated that last weekend while in a different room, their bed was located near the heater. They turned the heat down and the other resident (hereinafter R74) got upset and hit them on their forearm. A review of R186's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: staphylococcus infection, mild neurocognitive disorder, dementia with mood disturbance. A review of the residents Minimum Data Set (MDS) MDS noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (intact cognition). The resident also had a court appointed legal guardian. On 12/9/25 at approximately 1:44 PM, a phone interview was conducted with the resident's legal guardian. The Guardian was asked if they were aware of the alleged resident to resident incident. They reported that they did know about it via R186 and had a conversation with a Nurse, they believed it was the Assistant Administrator but could not confirm. The Guardian further reported that they asked the facility to provide photos of the injury. They stated they had not received them. A request was made for all Incident/Accident (IA) reports regarding R186. The Administrator/Abuse coordinator provided the IA and additional documentation including interviews. They also reported that the allegation was reported to the State Agency. A review of the IA revealed in part, the following: Physical Aggression Received.Resident (R186).Incident Location: Resident's Room.Nursing Description: was called into residents room by CNA (certified nursing assistant) reported that his roommate hit him and scratched him on the forearm noticed a bruise on his forearm and a 3cm (centimeter) skin tear actively bleeding.Bruise: Left forearm.Skin Tear: left forearm . Continued review of the IA documentation noted the following: Statement of Witness: .Resident Name (F186).Date of Interview (12/8/25).SW (social worker) met with resident to discuss incident over the weekend with his roommate. Resident stated the room was cold and I asked my helper to turn it to 72 degrees. My roommate did not want it at that temperature and became angry about it. He came over to me and attacked me. He hit my arm. Statement of Witness: .Resident Name (R74).Date of Interview (12/8/25).SW (Social Worker) met with resident to discuss incident over the weekend with his roommate. Resident stated, I did not hit him. I am tired of him not using his urinal. He consistently is urinating on the carpet. He is messy with his (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food when he is in the recliner. On 12/11/25 at approximately 9:15 AM, an interview was conducted with R74. R74 was alert and asked about the incident that occurred between him and his roommate. R74 reported that he did not care for R186 as he urinated and defecated on the floor. R74 stated on the day of the incident they got into an altercation about the temperature. R74 reported that they did hit R186, but they did not beat him up as he stated. R74 said they both hit each other. A review of R74's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: heart failure, type II diabetes and paranoid schizophrenia. A review of the resident's MDS assessment noted they had a BIMS score of 14/15 (intact cognition). Additional clinical review reported that the resident had had a prior altercation with another roommate on 9/24/25 as noted in a Charting Follow-up- Behavior: Resident (R74) became agitated and screamed at roommate. Additionally, another incident occurred on 7/27/25 between R74 and another resident that shared the bathroom. Again, it was alleged R74 was verbally aggressive and threated to go after him if he did not stop washing clothes in the shared bathroom. R74's care plan was reviewed and documented, .Focus: Resident has an impaired mood/psychiatric status related to paranoid schizophrenia.history of ramping situations up when upset over situations with other residents.history of making false allegations about incidents regarding other residents.History of making sexually inappropriate and rude comments about females related to their weight. On 12/11/25 at approximately 10:50 AM, an interview was conducted with the Administrator/Abuse coordinator. The Administrator stated that there was no skin assessment of R186's forearm prior to the incident on 12/7/25. They noted the incident had been reported to the State Agency and continued investigation was in process. R60 & R142: A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed an allegation It was reported the facility failed to protect the resident from a resident-to-resident physical abuse incident which did not result in injury. Documentation in the summary of incident revealed the incident occurred on 11/3/25 but no time was included in the incident summary provided. The incident was initially reported to the SA on 11/3/25 at 8:54 PM. The facility's investigation documented: .On 11/3/2025, resident (R60) had a disagreement in the Unit 2 common area over the loudness of the television as she requested for the television to be turned down. As a result, resident (R142) intervened and contact was made by (R60's) quad point cane to (R142's) leg. Pain and skin assessment completed. There was a small bump to (R142's) leg. No pain and resident (R142) indicated that she was fine. There were no new findings as a result of the assessments provided to (R60). (R60) was re-directed to the Unit 3 common area where her room is located and there is less stimulation. Both residents remain at the facility and feel safe. 5 day investigation to follow. The facility's conclusion to the investigation revealed they did not substantiate abuse occurred because there was no intent to harm, there was no harm or injury, and there was no allegation of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abuse made by either resident related to the alleged resident to resident incident. The small bruise that was identified has since been resolved. Using the reasonable person concept, it can be determined that the reasonable person would likely experience harm with the potential for more than minimal psychosocial harm (e.g. anger directed at the action or at a person) as a result of the physical abuse since there is an expectation that the resident would not have contact with another resident's cane and subsequent bruise and abrasion while in the facility. Review of R142's incident report provided by the Administrator dated 11/3/25 [which was completed by the former Director of Nursing (DON 'O')] documented: .Nursing Description: Resident was sitting in common area lounge with other residents watching TV, another female resident approached the group of people demanding the volume be turned down by a male resident who had the remote control, hitting the back of his chair with her cane when request was not obliged. (R142) interjected herself into situation resulting in female resident making contact with her LLE (Left Lower Extremity), leaving a bruise and a small bump, writer was able to redirect said female resident back to her hall. Resident Description: (R142) stated she was sitting in her wheelchair when another female resident came up and hit her with her cane when she was trying to defend herself by putting her hand up to block the cane from making further contact. Resident showed writer bump on lower extremity .Injury Type Abrasion .Left lower leg (front) .Bruise .Left lower leg (front) .Mental Status .Oriented to Person .Place .Situation .Time .Notes 11/4/2025 IDT (Interdisciplinary Team) reviewed incident from 11/3/25, guardian, provider, and management notified. Pain and skin assessment completed, bruise noted to left shin, resident denied pain. Resident was in common area when two other residents started to argue over the TV volume, this resident attempted to de-escalate the situation, during this attempt, the cane of one of the other residents made contact with this resident's leg. Residents were immediately separated. It should be noted that the facility's documentation of the investigation provided to the SA online did not identify/include the abrasion and new skin treatment orders as mentioned in the original incident report. Additionally, the above documentation was not accessible/available as part of the resident's electronic clinical record during the survey. Review of R60's clinical record revealed the resident was initially admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: vascular dementia mild with psychotic disturbance, type 2 diabetes mellitus without complications, adjustment disorder with mixed disturbance of emotions and conduct, adjustment insomnia, and unspecified psychosis not due to a substance or known physiological condition. According to the Minimum Data Set (MDS) assessment dated [DATE], R60 had a Brief Interview for Mental Status Exam (BIMS) score of 15/15 which indicated intact cognition and was independent with walking using a cane. Review of R142's clinical record revealed the resident was admitted into the facility on 5/21/24 and readmitted on [DATE] with diagnoses that included: alcohol dependence with alcohol-induced persisting dementia, degeneration of nervous system due to alcohol, malignant neoplasm of unspecified site of right female breast, generalized anxiety disorder, major depressive disorder recurrent, mild, and cognitive communication deficit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the MDS assessment dated [DATE], R142 scored a 7/15 on the BIMS exam which indicated severe cognitive impairment. Further review of R60 and R142's clinical records revealed no documentation of the resident-to-resident incident from 11/3/25. Additionally, there was no identification or mention of the incident from 11/3/25 included in documentation by the Nurse Practitioner (NP 'L'), Social Work, or Psych NP following this incident for either of the residents. Additionally, R142's skin assessment dated [DATE] documented new concern for .Left lower leg (front) .one inch bump with bruise . There was no identification of the abrasion as identified by DON 'O' on 11/3/25. Review of the orders included a skin treatment order entered by Nurse 'F' on 11/3/25 to start on 11/4/25 and discontinued on 11/7/25 with a note of scabbed over that read, clean LLE with normal saline, apply A&D (topical vitamin used to protect minor cuts and scrapes) ointment, cover with dry dressing. one time a day for Treatment for 7 Days. On 12/11/25 at 7:55 AM, an interview was conducted with the Administrator (also the facility's Abuse Coordinator). When asked how it was determined they did not substantiate abuse, the Administrator reported the resident does not have the cognition to formulate intent, there were different witness statements and there were no outcomes emotionally. The Administrator confirmed the incident was not witnessed by staff, only upon hearing yelling/commotion. They further reported both residents had guardians and stated just because contact was made, doesn't mean abuse occurred, there was no intent. When asked how they determined no harm was sustained despite the injuries documented to R142 and if utilizing the reasonable person concept, the Administrator reported they did identify a bruise and offered no further clarification. According to the facility's policy titled, Abuse, Neglect and Exploitation dated 1/10/2024: .Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish .Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Possible indicators of abuse include, but are not limited to .Physical marks such as bruises .Physical injury of a resident, of unknown source .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has two Deficient Practice Statements (DPS). DPS #1This citation pertains to intake #'s 2642115 and 2661022. Based on observation, interview, and record review, the facility failed to ensure scheduled IV (intravenous) antibiotics were administered per physician's orders for two residents (R#'s 185 and 183) of two residents reviewed for IV antibiotics resulting in verbalized complaints, frustration, delayed treatment for infections, and the potential for an extended stay due to missed medication doses. Findings include: R185 On 12/9/25 at 12:17 PM, R185 was observed in their room seated in their wheelchair. An IV pump and pole were present in the room. At that time an interview was conducted with R185 regarding their stay in the facility. R185 verbalized complaints they were not receiving their IV antibiotics as scheduled. They said they were to receive the medication three times a day and felt they had missed some of their doses. On 12/10/25 at 10:30 AM, a second interview with R185 was conducted and they indicated they did not receive their 6 AM dose of their IV antibiotic. R185 appeared upset, frustrated, and verbally expressed worry about the missed doses and how it would impact their recovery. 12/10/2025 at approximately 10:35 AM, R185's Nurse, Nurse 'W' was asked if R185 received their 6 AM dose of their IV antibiotic and said they did not. They were asked if they knew why and said they did not think the pharmacy delivered the medication overnight, so it was not available for the midnight shift nurse to administer. A review of R185's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: surgical aftercare and a MSSA (Methicillin Susceptible Staphylococcus Aureus) bacterial infection in their blood. The record further revealed R185 had intact cognition and admitted for physical rehabilitation and IV antibiotic therapy for the MSSA bacterial infection. A review of R185's physician orders and medication administration record (MAR) was conducted and revealed an order dated 12/6/25 for cefazolin (IV antibiotic) 2 gram IV every 8 hours scheduled for 6 AM, 2 PM, and 10 PM for 21 days. It was noted the first dose of the medication was administered at 10 PM on 12/6/25 when they arrived at the facility. The order for the medication was discontinued on 12/8/25 after the 6 AM dose was given and re-ordered to start on 12/8/25 at 10 PM. The documentation on the MAR was blank for the 12/8/25 dose scheduled for 2 PM and it was unclear why they did not receive that scheduled dose. Further review of R185's MAR revealed the 12/10/25 6 AM dose of cefazolin was blank on the MAR in congruence with R185 saying they did not receive it as scheduled. On 12/10/2025 at 3:18 PM, an interview was conducted with Registered Nurse (RN)/Unit Manager 'S' regarding R185's missing antibiotic medication administrations. Nurse 'S' said they did not know why the medication was discontinued on 12/8/25 and re-started on 12/8/25 at 10 PM causing them to miss the 2 PM dose. They further reported the dose missed at 6 AM on 12/10/25 was because the pharmacy did not deliver any medications due to the weather. On 12/11/25 at 12:05 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R185's missed IV antibiotics. The DON acknowledged the concern and indicated the doses may have been missed but they would be added on to the end of the course of treatment to ensure R185 got 21 days of their three times a day antibiotic. At that time, it was pointed out that for every three doses R185 missed (already having missed two, with several more days to go) would equate a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one extra day stay in the facility; to which the DON indicated they did not think about it in that way. R183 Clinical record review revealed R183 was admitted to the facility on [DATE] for weakness and deconditioning secondary to a stroke. R183 had a significant cardiac history for a prosthetic heart valve and was treated with intravenous (IV) antibiotics for infective endocarditis (infection and inflammation of the heart valve). R183's Brief Interview of Mental Status (BIMS) assessed on 8/13/25 scored 15/15 indicating no cognitive impairment. The State Agency received a concern identifying Nurse Practitioner (NP) L was informed that after a cardiology consult on 10/7/25, it was recommended for R183 to continue IV Vancomycin (antibiotic) until they were seen by their Infectious Disease (ID) doctor on 10/29/25. It was alleged the facility failed to order and administer the IV antibiotic. Record review of R183's Cardiology consult signed and dated on 10/7/25 recommended to continue Vancomycin IV until follow up with infectious Disease. Underneath the Cardiologists signature was an ineligible signature dated 10/8/25. Record review of a Progress note dated 10/8/25 at 8:00 AM authored by NP L read .medical history of vegetative endocarditis of prosthetic aortic valve. Pt (Patient) was on iv vancomycin, completed today. Pt had appointment with her cardiology yesterday, cardiology recommended to continue iv vancomycin until pt f/u with her infectious disease. Discussed with facility, iv vancomycin re-ordered to restart tomorrow. The Medication Administration Record (MAR) documented R183 had not received IV Vancomycin on 10/8/25 and 10/9/25. On 12/11/25 at approximately 11:00 AM the Director of Nursing (DON) confirmed that NP L was in the building and would send them down to the surveyor conference room for an interview. Approximately two hours lapsed, and Assistant Director of Nursing (ADON) B was asked if NP L was coming to the surveyor room at which time the ADON confirmed NP L had left the facility without seeing the surveyor. On 12/11/25 at 1:36 PM, NP L was contacted by telephone, was unable to access the Electronic Medical Record (EMR) and the surveyor had to read the documentation in question over the phone. NP L had recollection of R183 and history of the note from 10/8/25 and commented they collaborated with Infectious Disease RN N about reordering and did not reorder the medication. When asked why their progress note documented .iv vancomycin re-ordered to restart tomorrow. NP L did not provide an explanation and referred back that they spoke to ID RN N about it. On 12/12/25 at approximately 3:30 PM, an interview with the DON, ADON, and Infectious Disease RN N. The cardiology consult recommendation document was reviewed and the DON confirmed the ineligible signature and date of 10/8/25 was in fact that of NP L. ID RN N said they were approached by R183 on 10/9/25 asking why their antibiotic had not been given. RN N stated they had no knowledge of IV Vancomycin continuing and never collaborated with NP L about R183 and reordering the Vancomycin. ID RN N was very familiar with R183 and their diagnosis of endocarditis, immediately investigated their concern, confirmed that the antibiotic should (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had been ordered, was not, and had RN S obtain the order immediately. Record review of the of the medication order documented Vancomycin IV 1.25 grams (GM) for endocarditis was taken as a verbal order on 10/9/25 at 3:00 PM by RN S and was not administered to R183 until 10/10/25. A review of a facility provided policy titled, Medication Administration revised 1/2023 was conducted and read, .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. DPS #2 Based on observation, interview and record review, the facility failed to provide a comprehensive skin assessment and initiate considerations regarding treatment management for one (R91) of one reviewed for non-pressure-related skin ulcers/wounds. Findings include: Clinical record review revealed R91 was admitted to the facility on [DATE] with COPD (Chronic Obstructive Pulmonary Disease), cardiovascular failure, depressive and generalized anxiety disorders. R91's Brief Interview of Mental Status (BIMS) assessed on 11/19/25 scored 15/15 indicating no cognitive impairment. On 12/9/25 at 9:00 AM, during initial introductions, R91 voiced concern needing a dermatology consultation for a skin sore on both lower legs. R91 legs were observed with numerous rounds partially scabbed and open sores with inflamed red colored borders. R81 said they were admitted with sores appearing like insect bites, nothing has helped, and they are itching more. R91 was observed removing a medicine cup filled with an ointment off their bedside tray and said, this is what they gave me nothing is working and is told by the staff, try not to scratch them. Clinical record review revealed on 6/25/25 Nurse Practitioner (NP) L ordered a wound care consult .to follow open wounds lower extremities. Wound consult on 7/1/25 documented .Asked to see resident due to scratches and picking marks. Spoke to resident about her wounds and she told me that she has tic's under her skin that she has to pick out.This is clearly a psychiatric issue, and she should be followed by psychiatry. Record review of R91's Care Plan Initiated on 6/5/25 and revised on 8/29/25 documented .Resident has behavior(s)as evidenced by: picking at skin. Interventions include .Administer medications as ordered. Observe for effectiveness and side-effects.Encourage resident to ask questions when concerned with their medical condition to reduce anxiety. Record review of Progress Note dated 12/10/25 at 8:00 AM authored by NP L documented resident apply Triamcinolone Acetonide Ointment 0.1% to affected area topically every 8 hours as needed for rash and apply to bilateral legs. On 12/11/25 at approximately 11:00 AM the Director of Nursing (DON) confirmed that NP L was in the building and would send them down to the surveyor conference room for an interview. Approximately two hours lapsed, and Assistant Director of Nursing (ADON) B was asked if NP L was coming to the surveyor room at which time the ADON confirmed NP L had left the facility without seeing the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper storage of medications and biologicals for four of four medication carts reviewed for medication storage.Findings include: On 12/10/2024 at 9:10 AM, An observation of the Mum Front Medication Cart was conducted with Licensed Practical Nurse (LPN) F. The following medications were observed unpackaged and without patient identifiers: Second drawer was observed with loose medications including a white oval shaped tab, white round scored tab stamped 16, tallow round tab stamped 54, white scored tab. Third drawer base was observed with moderate amounts of red and brown colored spilled dried matter where liquid stock medications are stored. A liquid stained envelope with name of a resident was observed tucked into the corner containing four size 13 Kirkland Brand hearing aid batteries. Per LPN F the resident no longer at the facility. On 12/10/2024 at 9:30 AM, an observation of the Lilly Back Medication Cart was conducted with Registered Nurse (RN) G. The following medications were observed unpackaged and without patient identifiers: Second drawer was observed with loose medications including a purple round stamped 175, green oval stamped E47, peach oval stamped D 850, yellow oval stamped H88, two yellow oval tabs stamped 152, orange colored capsule, blue white capsule stamped [NAME]/Q02, pink capsule, three green oval tabs stamped A16, two round white tabs stamped HH974, two round stamped 127c, two pink oval shaped stamped 8945, orange round stamped 022, purple round tab stamped L17, blue round stamped HH205. Third drawer base was observed with chalklike crushed debris and red and brown colored spilled dried matter where liquid stock medications are stored. Fourth drawer contained an open pack of strawberry flavored hard candies. RN G was not sure who they belonged to and acknowledged food should not be stored in the medication cart. On 12/10/2024 at 10:00 AM, an observation of the [NAME] Medication Cart was conducted with LPN H. The following medications were observed unpackaged and without patient identifiers: First drawer was observed with four individual packaged Risperidone (an antipsychotic medication) with no resident identifiers. Second drawer was observed with loose medications including a round tab stamped V/15, blue white capsule R149, two white round tabs stamped P5, white round stamped EP116, blue round tab, oval round 216, white scored tab, round yellow tab stamped T230. Third drawer was observed with a single use vial of Cyclosporine (medication to reduce inflammation (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and improve tear production) eye drops with no resident identifier. LPN H remarked the name of the resident and when questioned how they knew the medication with no patient identifier, LPN H said it was the only resident on the unit who uses it. Top drawer of right side of cart where insulin, syringes, and glucometer supplies are stored was observed storing a single use vial of Cyclosporine, a yellow colored lighter, and a pair of sunglasses (unknown owner). LPN H acknowledged these items should not be stored amongst medications and medication supplies. LPN H accessed the units Medication Storage unit where an opened package of Froot Loop brand cereal was stored amongst medical storage supplies. On 12/10/25 at 4:07 PM, The Director of Nursing (DON) was informed of the medication cart and room storage observations. The DON acknowledged loose unidentified medication and no resident identifiers is not safe or proper storage. The DON remarked the Staff had brought the above findings to their attention prior to this interview. On 12/10/25 at 12:47 PM, an observation of a medication cart on Unit 3, stored in the hallway outside of room [ROOM NUMBER] revealed there were two clear cups stored on top of the cart. One cup contained two lancets (needles used to monitor blood sugar levels) with two glucometer test strips and the other cup was a smaller one-ounce cup which contained a clear, thicker liquid substance. There were multiple residents and staff observed passing directly by the medication cart. Further down the hallway, another Nurse (Nurse 'P') was observed at another medication cart. At 12:50 PM, Nurse 'P' was asked about who was assigned to the medication cart outside of room [ROOM NUMBER] and they reported they were in training and the main Nurse (Nurse 'G') was with another resident. Nurse 'P' was asked about the items stored on top of the medication cart and Nurse 'P' proceeded to pick up the cup and smell the contents and reported they thought it was icy hot (a topical pain reliever containing menthol) and left it on the top of the cart. Nurse 'P' then was asked about the lancets and glucometer test strips and if those should be stored on the top of the cart and they stated those should've been locked up. Nurse 'P' proceeded to remove the lancets to place back into the cart and then removed the two glucometer strips with their bare hands and placed the strips back into the original glucometer strip container in the cart. On 12/10/25 at 1:09 PM, Nurse 'G' returned to the hallway. When informed of the storage of the biological (clear substance in cup) on the top of the medication cart, Nurse 'G' proceeded to discard the cup into the open garbage attached to the lower side of the medication cart which was full (the cup remained stored on top of the garbage). When informed of the storage of the lancets on top of the med cart and the observation of Nurse 'P', Nurse 'G' reported that should not have occurred and would follow-up with the nurse. According to the facility's policy titled, Medication Storage dated 1/30/2024: .It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .All drugs and biologicals will be stored in locked compartments .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement appropriate infection control practices relating to laundry service and transmission based precautions for one resident (R185), of one resident reviewed for transmission based precautions, resulting in the spread of infection. Due to faulty infection control practices in the laundry, this his deficient practice had the potential to affect all residents residing in the facility. On 12/9/25 and 12/10/25, multiple observations of R185's room revealed a sign that indicated they were on contact isolation precautions (transmission based precaution that requires the use of an isolation gown and gloves when entering the room) as well as personal protective equipment (isolation gowns, gloves, masks, face shields) for use located in the hallway next to R185's room. On 12/11/25 at 9:20 AM, Phlebotomist 'W' was observed to enter R185's room with their phlebotomy kit (a bag with blood draw supplies). Upon entry to the room they were not observed to don an isolation gown. When they entered the room, they were further observed to place their phlebotomy kit on the floor and obtain a lab specimen from R185. After exiting the room, they were not observed to sanitize the kit that had been placed on the floor in the contact isolation room. On 12/11/25 at 9:25 AM, an interview with Phlebotomist 'W' was conducted and they were asked why they did not don an isolation gown prior to entering the room. They said they did not know R185 was on contact isolation precautions. They were then asked if they saw the sign hanging on the door that indicated the room was a contact isolation room and they offered no response. On 12/11/25 at 12:05 PM, an interview was conducted with the facility's Director of Nursing, and they indicated Phlebotomist 'W' should have donned the appropriate personal protective equipment prior to entering the room. A review of a policy titled, Transmission-Based (Isolation) Precautions revised 12/2023 was conducted and read, .'Contact Precautions' refers to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment .9. Contact Precautions- .c. Healthcare personal caring for residents on Contact Precautions wear a gown and gloves for interactions that involve contact with the resident or potentially contaminated areas in the resident's environment . On 12/11/25 at approximately 2:30 p.m., a review of the linen/personals was conducted in the laundry room with laundry aide V (LA V). In the main washing room, three bins full of clean personal clothing were located uncovered in close proximity to the washing machine. LA V was queried if they had a room for clean clothing after it has been washed and they reported they did but it was not being used for clean storage at that time. LA V was queried how they wash the soiled linen and clothing and they reported they take it to the washing machine from the dirty room and put it in. LA V was asked why the clean clothing was located close to the washing machine where they fill with soiled clothing and linen and they acknowledged they understood the risk of contamination from the soiled clothing and did not think it was being done correctly. At that time, the Middle washing machine was inspected and revealed the back right corner was leaking water and had a standing puddle of water behind it. LA V was queried regarding the leaking washing machine and the large puddle of stagnant water, and they indicated they would have to let maintenance know about the water.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to thoroughly inventory and document personal belongings upon admission for one resident (R123), of one resident reviewed for personal belongings, resulting in the potential for denial of replacement of missing items and valuables. Findings include: On 12/9/25 at 11:56 AM, R123 was observed lying in bed in their room. They were asked about their stay at the facility and verbalized a complaint regarding the facility losing their hearing aids and their ice packs brought from home. R123's room was observed to contain many personal items of value, among them: a cell phone, electric razor, and a tablet. They were asked if the facility was aware they were missing the items and said they alerted someone but did not know who. They further said the person they alerted dismissed their concern because the items were not listed on their, inventory sheet. They were asked if staff assisted them to fill out a grievance form and said they did not. On 12/10/25 at approximately 11:00 AM, a review of R123's INVENTORY OF PERSONAL EFFECTS form scanned into their record was reviewed. The form had only one item, wheelchair catalyst written in ink pen on the form. It was noted the form had an area to inventory various electronics such as a cell phone or a tablet as well as an area to document Personal Assistive Devices, such as hearing aids. The form was dated 11/13/25 and signed by a staff member but was not signed by R123. On 12/11/15 at 9:20 AM, an interview was conducted with Nurse 'F' (assigned to R123's care) and they were asked who filled out the INVENTORY OF PERSONAL EFFECTS forms when a resident admits to the facility. They said it was usually the certified nurse aides or sometimes a nurse. On 12/11/25 at 12:05 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R123's inventory form and their missing personal items (hearing aids and ice packs). They reviewed the form at that time and said the form should have been completely filled out by staff and signed by R123. A review of R123's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: spinal fusions, spinal instabilities, falls, traumatic subarachnoid hemorrhage (brain bleed), diabetes, and heart disease. A review of R123's most recent Minimum Data Set assessment dated [DATE] indicated R123 had intact cognition. A review of a facility provided policy titled, Resident Personal Belongings revised 1/2022 was reviewed and read, It is the policy of this facility to protect the resident's right to possess personal belongings .1. All resident possessions, regardless of their apparent value to others, will be treated with respect .3. All resident personal items will be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be retained in the record .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the call light was in reach for one resident (R114), of one resident reviewed for accommodation of needs, resulting in verbalized frustration and the potential for a delay in staff response to resident needs. Findings include: On 12/9/25 at 11:49 an, R114 was observed in their room. They were sitting in their recliner with their legs elevated. The recliner was positioned approximately five feet away from the right side of their bed. An interview with R114 was conducted and they said they were experiencing pain. They were asked if they made the nurse aware, and said they did not. They were then asked if they could activate their call light to request their nurse and said, I can't reach it, it's way over there. R114 pointed to their call light that was observed clipped to their bed, approximately five feet away from where they were seated in their recliner. R114 was asked if they were able to ambulate from their recliner to the bed to get the call light and said they could not. R114 appeared frustrated, sighed and said, It's such a simple thing, regarding having their call light left in their reach when they were assisted to their recliner. On 12/9/25 at 11:56 AM, Nurse 'S' was asked about R114's call light being out of reach and said it should have been within reach. On 12/11/25 at 11:58 AM a review of R114's clinical record revealed they most recently readmitted to the facility on [DATE] with diagnoses that included: humerus fracture, syncope and collapse, bone cancer, breast cancer, brain cancer, pain, and muscle weakness. R114's most recent Minimum Data Set assessment dated [DATE] indicated R114 was cognitively intact. A review of a facility provided policy titled, Call Lights: Accessibility and Timely Response revised 12/28/23 was reviewed and read, .1. Staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access to the call light .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their grievance process for one resident (R185) of one resident reviewed for grievances, resulting in verbalized complaints and unresolved grievances. Findings include: On 12/9/25 at 12:17 PM, R185 was observed in their room seated in their wheelchair. An IV (intravenous) pump and pole were present in the room. At that time an interview was conducted with R185 regarding their stay in the facility. R185 verbalized complaints they were not receiving their IV antibiotics as scheduled. They said they were to receive the medication three times a day and felt they had missed some of their doses. On 12/10/25 at 10:30 AM, a second interview with R185 was conducted and they indicated they did not receive their 6 AM dose of their IV antibiotic. R185 appeared upset, frustrated, and verbally expressed worry about the missed doses and how it would impact their recovery. On 12/10/2025 at approximately 10:35 AM, R185's Nurse, Nurse 'W' was asked if R185 received their 6 AM dose of their IV antibiotic and said they did not. They were asked if they knew why and said they did not think the pharmacy delivered the medication overnight, so it was not available for the midnight shift nurse to administer. A review of R185's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: surgical aftercare and a MSSA (Methicillin Susceptible Staphylococcus Aureus) bacterial infection in their blood. The record further revealed R185 had intact cognition and admitted for physical rehabilitation and IV antibiotic therapy for the MSSA bacterial infection. R185's Medication Administration Record (MAR) was reviewed and revealed a missed dose of their intravenous antibiotic scheduled for 12/10/25 at 6 AM. Continued review of the record revealed a Pertinent Charting-Behavior note entered into the record by Registered Nurse (RN)/Unit Manager 'S' dated 12/10/25 at 8:19 AM that read, .Note Text: Event Date: 12/10/2025 Behavior Displayed: resident making accusations of staff not providing care .Accusing staff of not providing medications .verbally aggressive to staff. Precipitating factors/events: resident forgetful of care/medication administration. Intervention(s) attempted: attempted speaking with resident. He voices understanding but with next person will again be verbally aggressive Intervention results: unsuccessful .On 12/10/2025 at 3:18 PM, an interview was conducted with Registered Nurse (RN)/Unit Manager 'S' regarding their Behavior note entered into the record at 8:19 AM on 12/10/25. They said R185 received their medication but was forgetful. At that time, it was brought to their attention, R185 in fact had not received their 6 AM antibiotic medication as evidenced by the MAR and an interview with Nurse 'W' and that caused them to be upset. RN 'S' was asked if they believed R185 had a valid concern and agreed. They were asked if they assisted R185 with filling out a grievance form and said they did not. They were asked why they did not take a grievance and said they were the unit manager and they, handled it. On 12/11/25 at 12:05 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R185's concerns with not receiving their scheduled IV antibiotics. They were asked if they thought R185 should have been offered or assisted to file a grievance and said they should have; so, the root cause could be investigated and R185 could have been given a clear explanation on what happened and why their medications were not given. A review of a facility provided policy titled, Quality Assistance Procedure revised 10/2023 was conducted and read, .1. Any resident, his or her representative .may file a Quality Assistance Form concerning treatment, medical care .5. Upon receipt of a written Quality Assistance Form/request, the department manager will investigate the allegations and submit a written report of such findings to the administrator .7. The resident or person filing the Quality Assistance Form on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Howell	1333 W Grand River Howell, MI 48843

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure allegations of abuse were reported to the Administrator/Abuse coordinator and to the State Agency for one R (68) of nine residents reviewed for abuse. Findings include:On 12/9/25 at approximately 9:40 AM, R68 was observed sitting in their wheelchair in their room. The resident was alert and able to answer questions asked. When asked if they felt safe in the facility, they reported that some staff are often rude, disrespectful and at times not physically careful.A review of R68's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: type II diabetes, difficulty walking and acute respiratory failure. A review of R68's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (intact cognitive functioning) and was their own responsible party.Continued review of R68's clinical record revealed, in part, the following:11/9/25: Pertinent Charting Behavior: .Resident screaming at staff she wants to be sent out.Resident assisted to restroom.via sit-to-stand and after toileting.stating staff pushed her into a wall. X2 persons present during patient care due to allegations. Authored by Nurse U (*It should be noted that Nurse U was no longer employed by the facility).A request was made for all Incident and Accident (IA) reports pertaining to R68. No IA's pertaining to the allegation of physical abuse provided.On 12/11/25 at approximately 11:43 PM, an attempt to contact Nurse U via phone. A voice message was left. No return call was made prior to the end of the Survey.On 12/11/25 at approximately 11:52 PM, an interview was conducted with the Administrator/Abuse Coordinator regarding the allegation made by R68. The administrator reported that they were not made aware of the allegation and noted that Nurse U was terminated from employment based on attendance. The Administrator/Abuse Coordinator confirmed that all allegation pertaining to physical abuse should be reported to them.A review of the facility policy titled, Abuse, Neglect and Exploitation (1/10/24) revealed, in part: .It is the policy of this facility to provide protections for the health, welfare and rights of each resident.Abuse: means the willful infliction of injury.punishment with resulting physical harm.which can include staff to resident abuse.Reporting/Response.Reporting of alleged violations to the Administrator.immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.or not later than 24 hours if the allegations do not involve abuse.

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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 initiate their bowel protocol for one resident (R123) of one resident reviewed for bowel and bladder, resulting in constipation and verbalized complaints of pain and discomfort. Findings include: On 12/9/25 at 11:56 AM, R123 was observed in their bed. At that time, an interview was conducted and R123 reported they had not had a bowel movement in a week. They were asked if staff were aware of his situation and said they were, and someone told them they were going to get a suppository later on in the day. R123 expressed feelings of anxiousness, pain, and discomfort in their stomach. They further reported they had several of their thoracic vertebrae fused in their spine and at home they were on a strict bowel regimen to ensure regularity. They expressed frustration with staff not listening to them and said they had been hospitalized in the past because of constipation and feared having to be hospitalized again. A review of R123's clinical record revealed they were admitted to the facility on [DATE] with diagnoses that included: falls, spinal fusion, traumatic subarachnoid hemorrhage (brain bleed), heart disease, and diabetes. R123's Minimum Data Set assessment dated [DATE] revealed they had intact cognition. R123's Certified Nurse Aide task for bowel movements was conducted and revealed the last documented bowel movement was on 12/3/25. On 12/10/25 at approximately 3:40 PM, a nursing progress note dated 12/10/25 at 2:58 PM entered into the record by nurse 'S' read, .resident would like to have a suppository daily. states he believes that he has a neuro disorder from a mva (motor vehicle accident) years ago and that he has trouble going and that it causes pain to shoot down his legs when he cannot go NP/MD (Nurse Practitioner/Medical Doctor) notified to eval (evaluate) resident for suppository. Further review of the record revealed a physician's order dated 11/26/25 for a bisacodyl rectal suppository every 24 hours as needed if they had not had a bowel movement in two days, however; R123's December Medication Administration Record (MAR) did not reveal any administrations of the as needed suppository to treat R123's constipation. On 12/11/25 at approximately 11:50 AM, a follow-up interview was conducted with R123. They were asked if they received a suppository and had a bowel movement. They said they finally received the suppository and they had a huge bowel movement. R123 went on to describe the bowel movement as feeling like they were passing, a baseball bat. They expressed relief but wondered why they had to wait so long. On 12/11/25 at 12:05 PM, an interview was conducted with the facility's Director of Nursing (DON). They were informed R123 went several days without a bowel movement despite having an order for an as needed order for a suppository. The DON said the facility should have followed their bowel protocol and the physician's orders. A request for a policy on the facility's bowel protocol was made; however the Administrator reported via e-mail on 12/11/25 at 3:07 PM the facility did not have a policy for bowel protocol.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids 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 ensure dressings were changed in a timely manner for a peripherally inserted central catheter for one resident (R185), of one resident reviewed for peripherally inserted central catheters, resulting in the potential for the development of infection. Findings include: On 12/9/25 at 12:17 PM, R185 was observed in their room seated in their wheelchair. An interview was conducted at that time and R185 expressed some concerns with their IV (intravenous) antibiotic medications. R185 was asked how they received their IV medications and said they had a PICC (peripherally inserted central catheter) line in their right arm. With their permission, an observation of the line and the insertion site was conducted and it was noted the dressing on the PICC line was dated 12/2/25. On 12/10/25 at 10:32 AM, a second observation of R185's PICC line dressing revealed it remained with the date of 12/2/25. They were asked if the dressing to their PICC line had been changed since they admitted to the facility and they said no. A review of R185's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: surgical aftercare and MSSA (Methicillin Susceptible Staphylococcus Aureus) bacterial infection. The record further revealed R185 had intact cognition and admitted for physical rehabilitation and IV antibiotic therapy for the MSSA bacterial infection. A review of R185's physician orders, medication administration record (MAR), and treatment administration records (TAR) were conducted and revealed an order for a dressing change to the PICC line site scheduled for 12/7/25 and signed out as being completed, despite the dressing being dated 12/2/25 and R185 reporting it had not been done since their admission on [DATE]. On 12/10/25 at 3:18 PM, an interview was conducted with Registered Nurse (RN)/Unit Manager 'S'. They were informed R185's PICC line dressing was observed dated 12/2/25 despite the TAR indicating the dressing was changed on 12/7/25. They said the dressing should have been changed per the schedule and they would look into the concern. A review of a facility provided policy titled Care and Maintenance of Central Venous Catheter revised 12/2023 was conducted and did not define the frequency of PICC line dressing changes, however; an article titled Peripherally Inserted Central Catheter (PICC) Line Placement - StatPearls - NCBI Bookshelf from the website for the National Institute for Health read, .The dressing and venotomy site should be inspected to check for bleeding and erythema. Dressings should be changed at least once weekly .

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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 ensure adequate documentation/monitoring of suctioning administration and cleaning were followed for one resident (R46) of one resident reviewed for oral suctioning. Findings include: On 12/09/2025 at approximately 10:29 a.m., R46 was observed in their room, laying in their bed. R46 was observed to have a suctioning machine (a machine used to expel secretions) next to their bed. R46's suctioning machine was observed to have multiple tubes attached to it that were observed to have dried mucus inside. R46's suctioning container was observed to be 3/4 full of dried green mucus. No dating was observed on the tubing or the container to document the last time it had been changed and emptied. On 12/10/25 at approximately 9:42 a.m., R46 was observed in their room, laying in their bed. R46 was observed to have a suctioning machine (a machine used to expel secretions) next to their bed. R46's suctioning machine was observed to have multiple tubes attached to it that were observed to have dried mucus inside. R46's suctioning container was observed to be 3/4 full of dried green mucus. No dating was observed on the tubing or the container to document the last time it had been changed and emptied. On 12/11/25 at approximately 9:18 a.m., R46 was observed in their room, laying in their bed. R46 was observed to have a suctioning machine (a machine used to expel secretions) next to their bed. R46's suctioning machine was observed to have multiple tubes attached to it that were observed to have dried mucus inside. R46's suctioning container was observed to be 3/4 full of dried green mucus. No dating was observed on the tubing or the container to document the last time it had been changed and emptied. On 12/11/25 at approximately 10:16 a.m., R46 was observed in their room with Nurse R. Nurse R was shown R46's suction machine with the tubing not dated and they indicated that it should be dated with the last time it was changed. Nurse R indicated they would get new tubing and a dating label for them. Nurse R was queried regarding how often the container of secretions should be emptied and or replaced and they indicated they did not know. Nurse R was queried how often R46 was receiving suctioning, and they reported that they did it themselves and did not know when they last suctioned themself. Nurse R was queried how often and when R46 was performing self-suctioning and they reported they did not know On 12/10/25 the medical record for R46 was reviewed and revealed the following: R46 was initially admitted to the facility on [DATE] and had diagnoses including Interstitial emphysema. A review of R46's MDS (minimum data set) with an ARD (assessment reference date) of 12/3/25 revealed R46 needed assistance from facility staff with most of their activities of daily living. R46's BIMS score (brief interview of mental status) was seven documenting severely impaired cognition. A review of R46's care plan revealed the following: Focus-Resident has an impaired pulmonary/respiratory status related to: history of acute hypoxic respiratory failure, uses bedside suction, and emphysema Date Initiated: 09/08/2023 .Interventions-Uses bedside suction ad lib. Ensure tubing and apparatus are cleaned and dated. Date Initiated: 08/16/2024 . A Physician's order revealed the following: Bedside Suction as needed Patient does suction self as needed. -Start Date-08/31/2022 A review of R46's suctioning documentation in the December 2025 medication administration record (MAR) revealed no documentation of R46 having completed bedside suctioning. On 12/11/25 at approximately 12:40 p.m., during conversation with Respiratory Therapist Q (RT Q), RT Q was queried regarding the documentation of self -suctioning performed by R46 and they indicated they did not have a current way to track self-suctioning, but that they would have to implement a way for the Nurses to ask R46 if they had suctioned that day or shift and be able to document it in the record. RT Q was queried regarding the documentation of changing the canister and tubing for the suctioning machine, and they reported when it is changed, it should be dated on the tubing and canister and that since the facility was getting more residents with suction machines, education was going to be provided to the Nurses on the requirements.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 electronic medical records for two (R60 and R142) of two residents reviewed for medical records. Findings include:A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed an allegation It was reported the facility failed to protect the resident from a resident to resident physical abuse incident which did not result in injury. Documentation revealed the incident occurred on 11/3/25 but no time was included in the incident summary provided.The facility's investigation documented, in part: .On 11/3/2025, resident (R60) had a disagreement in the Unit 2 common area over the loudness of the television as she requested for the television to be turned down. As a result, resident (R142) intervened and contact was made by (R60's) quad point cane to (R142's) leg. Pain and skin assessment completed. There was a small bump to (R142's) leg. No pain and resident (R142) indicated that she was fine. There were no new findings as a result of the assessments provided to (R60).The facility's conclusion to the investigation revealed they did not substantiate abuse occurred because there was no intent to harm, there was no harm or injury, and there was no allegation of abuse made by either resident related to the alleged resident to resident incident. The small bruise that was identified has since been resolved.Further review of additional documentation included an incident report for R142 provided by the Administrator from 11/3/25 which was completed by the former Director of Nursing (DON ?O'). This documentation included: .Nursing Description: Resident was sitting in common area lounge with other residents watching TV, another female resident approached the group of people demanding the volume be turned down by a male resident who had the remote control, hitting the back of his chair with her cane when request was not obliged. (R142) interjected herself into situation resulting in female resident making contact with her LLE (Left Lower Extremity), leaving a bruise and a small bump, writer was able to redirect said female resident back to her hall. Resident Description: (R142) stated she was sitting in her wheelchair when another female resident came up and hit her with her cane when she was trying to defend herself by putting her hand up to block the cane from making further contact. Resident showed writer bump on lower extremity .Injury Type Abrasion .Left lower leg (front) .Bruise .Left lower leg (front) .Mental Status .Oriented to Person .Place .Situation .Time .Notes 11/4/2025 IDT (Interdisciplinary Team) reviewed incident from 11/3/25, guardian, provider, and management notified. Pain and skin assessment completed, bruise noted to left shin, resident denied pain. Resident was in common area when two other residents started to argue over the TV volume, this resident attempted to de-escalate the situation, during this attempt, the cane of one of the other residents made contact with this resident's leg. Residents were immediately separated.It should be noted that the facility's documentation of the investigation provided to the SA did not identify/include the abrasion and new skin treatment orders. The only mention of R142's abrasion was on the actual incident report completed by DON ?O' and this documentation was not accessible/available as part of the resident's electronic clinical record during the survey.Review of R60's clinical record revealed the resident was initially admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: vascular dementia mild with psychotic disturbance, type 2 diabetes mellitus without complications, adjustment disorder with mixed disturbance of emotions and conduct, adjustment insomnia, and unspecified psychosis not due to a substance or known physiological condition.According to the Minimum Data Set (MDS) assessment dated [DATE], R60 had a Brief Interview for Mental Status Exam (BIMS) score of 15/15 which indicated intact cognition and was independent with walking using a cane.Review of R142's clinical record revealed the resident was admitted into the facility on 5/21/24 and readmitted on [DATE] with diagnoses that included: alcohol dependence with alcohol-induced persisting dementia, degeneration of nervous system due to alcohol, malignant neoplasm of unspecified site of right female (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breast, generalized anxiety disorder, major depressive disorder recurrent, mild, and cognitive communication deficit.According to the MDS assessment dated [DATE], R142 scored a 7/15 on the BIMS exam which indicated severe cognitive impairment.Further review of R60 and R142's clinical records revealed no documentation of the resident to resident incident from 11/3/25.Review of the skin assessments for R142 included one dated 11/3/25 at 9:44 PM documented, .Left lower leg (front) .one inch bump with bruise .Treatment initiated .Yes .Are there any existing abnormal skin areas . There was no mention of an abrasion as documented in the incident report.Review of the physician orders for R142 included a skin treatment order entered by Nurse ?F' on 11/3/25 to start on 11/4/25, and discontinued on 11/7/25 with a note of scabbed over that read, clean LLE with normal saline, apply A&D (topical vitamin used to protect minor cuts and scrapes) ointment, cover with dry dressing. one time a day for Treatment for 7 Days.Review of the interdisciplinary progress notes for both R60 and R142 since 11/3/25 revealed there no identification of the resident-to-resident incident from 11/3/25 or any details of follow-up/evaluation. The documentation as available in the clinical record would not inform the reader that any incident had occurred.Review of the provider visit by Nurse Practitioner (NP ?L') on 11/4/25 at 8:00 AM and 11/7/25 at 8:00 AM revealed there was no reference or discussion that they had assessed the resident following the resident-to-resident incident on 11/3/25. Both assessments contained the same skin notes, .Skin.Negative: Wounds, Erythema, Rash, Bruising.This evaluation conflicted with the identification of a one inch bruise and abrasion by nursing on 11/3/25 as well as treatment orders and documented treatments provided to R142 on 11/4, 11/5, and 11/6.Review of R142's provider visit on 11/12/25 at 6:51 PM by Psychiatry NP ?V' revealed their documentation did not identify if they had been notified and/or aware of the resident-to-resident incident from 11/3/25.On 12/11/25 at 7:55 AM, an interview was conducted with the Administrator (also the facility's Abuse Coordinator) to review the details of the incident between R60 and R142. At that time, the only documentation provided for review was the documentation submitted to the SA and the residents' electronic clinical records.On 12/11/25 at 10:10 AM, the Administrator was asked about the lack of documentation that any incident had occurred on 11/3/25 for both R60 and R142 and they reported that information was in an incident report. When informed that incident reports were not available to the survey team in the electronic medical records, and also requested they provide an explanation as to why the documentation from the interdisciplinary team (including social services, NP ?L' and psych consultant) did not include/identify any reference to the incident in their documentation of visits following the incident, the Administrator reported the psych consultant was aware and the notes entered on the incident report had some sections go into the record. The Administrator was requested to provide that documentation and was informed there was no documentation included currently in the medical record and they reported they would follow-up.On 12/11/25 at 10:25 AM, the Administrator reported they had R142's incident report and provided a copy. They further reported they had to create a ticket with IT (Information Technology) regarding the IDT notes at the bottom of the incident report because that information should've gone into the clinical record and they confirmed it did not.When asked what the facility's expectation was regarding documentation following incidents, especially given one that was reported to the SA, the Administrator reported when the staff completed an incident/accident report the staff notify the provider, we normally have social services do wellness checks and psych consultant (NP ?V?) comes in and sees the resident. When asked why that was not reflected in any of the IDT's documentation, the Administrator offered no further explanation. On 12/11/25 at 10:33 AM, the facility's corporate clinical support provided a copy of an email request from the DON regarding an IDT note from a Risk Management record (not available to the survey team) that needed to be added to the resident's chart.On 12/11/25 at 10:51 AM, the Administrator was requested via email to provide the contact information for NP ?L' as well as a facility policy that addressed complete/accurate clinical recordsOn 12/11/25 at 10:53 AM, the Administrator was requested via email to provide an incident report for R142 (as of that time an incident report was only provided for R60 and not included in the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of the incident file provided during survey.On 12/11/25 at approximately 11:00 AM the DON was informed the survey team wanted to speak with NP ?L' and the DON reported NP ?L? was currently in the facility and had been notified of the request.On 12/11/25 at 11:35 AM, an interview was conducted with the Administrator and Director of Nursing (DON). When queried about the treatment order and concerns that were not identified on the facility's skin assessment, nor were mentioned in any details in the progress notes, and discrepancies and lack of identification in the practitioner's notes, or social services, the Administrator questioned why this had not come up in the past as their process had not changed. Neither the DON or the Administrator offered any further explanation.On 12/11/25 at 12:55 PM, a phone interview was conducted with Psych NP ?V'. When asked about their process for documentation of their evaluation of residents for resident-to-resident incidents and whether that should be included within their documentation, Psych NP ?V' stated they had previously spoke to the Administrator before this phone call and further reported they had been notified but couldn't recall the details exactly and not sure of the exact date, but didn't verbally think as an extreme need for psychiatry so I did a routine visit and further reported they didn't always reference that in their evaluations. When asked how that could be determined based on the lack of documentation, Psych NP ?V' offered no further explanation.On 12/11/25 at approximately 1:30 PM, the survey team was informed by the Assistant Director of Nursing (ADON) that NP ?L? was no longer at the facility, but confirmed NP ?L? had been informed of the request to meet.On 12/11/25 at 1:45 PM, a phone interview was conducted with NP ?L'. When asked if they had been notified of the survey team's request to meet while they were in the facility, NP ?L' reported they had not and was told the Administrator wanted to see them. They further reported they were unable to return, did not have access to the medical records, but agreed to the interview. When asked about their knowledge of the resident-to-resident incident between R60 and R142 on 11/3/25, NP ?L' reported they were not aware of that. When asked about their documentation including multiple visits post incident in which they documented no skin issues, despite orders in place to address the bruise and abrasion, NP ?L' reported if they documented that, then they evaluated the skin and saw no issues. When asked to explain the discrepancies, NP ?L' offered no further response. On 12/11/25 at 3:29 PM, the Administrator was requested for a facility policy for complete/accurate medical records and at 3:34 PM, they responded, We do not have a policy for complete/accurate medical records.