STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235333	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency, A Villa Center	12575 S Telegraph Rd Taylor, MI 48180

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to ensure there was a Registered Nurse (RN) for 8 consecutive hours 7 days a week. This deficient practice has the potential to affect all residents residing in the facility.Findings include:During review of the facility's staffing schedule from 10/1/2025 through 1/14/2026 it was noted there was no RN working in the facility for the entire day of 12/28/25. On 1/15/2026 at 2:06 PM the Director of Nursing (DON) reviewed the facility's staffing schedule and confirmed there was no RN on 12/28/25. The DON said, The RN scheduled to work that day called in sick. There is no documentation to indicate the facility was able to fill that staffing vacancy with another RN. The DON reported there was no facility policy specific to RN coverage because it was a regulation.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to: 1. Ensure trash cans were clean and properly lined; 2. Ensure pans were properly cleaned and allowed to air dry before stacking; 3. Properly date-label food stored in the walk-in cooler; 4. Ensure staff food and personal items were not commingled with residents' food; 5 Ensure proper cooling of cooked, potentially hazardous (time-temperature for safety) food; and 6. Ensure food service equipment was maintained in a safe and sanitary operating condition. These deficient practices had the potential to affect all the residents who consumed food from the kitchen, resulting in the potential for foodborne illness. Findings include:On 1/13/26 at 8:50 AM, a kitchen tour was conducted with Dietary Director (DD) F. The following items were noted: Two trash cans, full of trash, were observed without liners. The inside of both trash cans were stained with moldy-looking black, slimy patches. The following was observed stored in the clean pot/pan area:One full-size pan and one full-size draining pan were stained with food debrisTwo quarter-size pans nestled together, and two half-size pans nestled together were wet.Two full-size pans were nestled together and were wet and soiled with food debris.A stack of eight full-size sheet pans were stored right side up. The drain lines from the three-compartment sink and the dish machine were not properly air-gapped. The following was observed in the walk-in cooler:A case of peas was not fully closed, subjecting the contents to contamination. A multi-shelf metal cart contained the following: a disposable food storage container of cooked seasoned steak fries; a staff member's personal pot; a 20-ounce size disposable cup, essentially empty but contained the remnants of an orange-colored liquid; and 1/4 size pan containing folded towels. The following items, also stored on this metal cart, were not labeled or dated: 1/4-size pan of yellow pureed food, 1/4-size container of orange and yellow pureed food, 1/4-size pan of ground meat which also contained a full hot dog; and a 1/2-size pan of cooked rice. A second multi-shelf metal cart contained the following items that were not labeled or dated: 1/3 size pan of pureed yellow substance and 1/4 size pan of ground meat. On 1/15/2026 at 12:40 PM, DD F provided no evidence that the cooked food observed in the walk-in cooler had been properly cooled. DD F said food should be cooled properly to avoid bacterial food growth. DD F added that food stored in the walk-in cooler should be properly dated and labeled in order to know when it should be discarded and to properly identify it. DD F said pans should be properly cleaned and fully dry prior to being stored face down. DD F expected the garbage cans to be cleaned and lined daily, and the drain lines from the three-compartment sink be properly air gapped to prevent sewage backing up into the sink. On 1/16/2026 at 9:51 AM, the Nursing Home Administrator (NHA) said kitchen staff were expected to label and date stored food and only resident food should be stored in the kitchen coolers, and that trash cans should have liners. On 1/16/26 at 1:30 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information when asked. A review of the 2013 FDA Food Code revealed the following:- Section 3-101.11, Safe, Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under S 3-601.12, honestly presented.- Section 3-501.14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 135 F to 70 F; and (2) Within a total of 6 hours from 135 F to 41 F or less.- Section 4-901.11, Equipment and Utensils, Air-Drying Required. After cleaning and sanitizing, equipment and utensils shall be air-dried.- Section 5-402.11. Backflow prevention. Except as specified in paragraph (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed.- 5-501.116 Cleaning receptacles. Soiled receptacles and waste handling units for refuse, recyclables, and returnables shall be cleaned at a frequency necessary to prevent them from developing a buildup of soil or becoming attractants for insects and rodents.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure meals were served at palatable temperatures for multiple residents in the facility, resulting in dissatisfaction with the meal experience. Findings include: On 1/14/26 at 8:50 AM, the last tray on a fourth-floor breakfast meal cart was obtained to be used as a test tray. Certified Nurse Aide (CNA) E was present during the testing of food temperatures on the breakfast tray. The following temperatures were obtained using a metal stem thermometer: Scrambled eggs: 95 ºF (Fahrenheit) Oatmeal 115 ºF 8 oz. carton of milk 52.8 ºF The temperatures of the following items were not obtained using a thermometer, but congruent observations were made: The raisin bread was room temperature to the touch. The bacon was cool to the touch. On 1/14/2026 at 8:57 AM, R4 was observed eating breakfast and commented that the temperature of the oatmeal was hot, but the temperature of the eggs was so, so. On 1/14/2026 at 9:11 AM, R185 was observed eating breakfast and commented that his eggs were cold. R185 requested that butter be spread on his eggs. When this was done, the butter did not melt. On 1/15/2026 at 12:57 PM, Dietary Director (DD) F was queried about his expectations for food temperatures at the point of service. DD F said scrambled eggs should be at least 120 degrees. Raisin bread was okay at room temperature, but the bacon should be hot. DD F stated, We will have to revisit how we cook and serve bacon. On 1/16/26 at 10:10 AM, the Nursing Home Administrator (NHA) said that food temperatures were expected to be within the range that they are supposed to be. On 1/16/26 at 1:30 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information when asked. Anonymous Resident Council- On 1/14/26 at 2:00 p.m. an Anonymous Resident Council meeting was held with ten cognitively intact residents that resided on the second, third, and fourth floors of the facility. Seven of ten residents verbally expressed strong dissatisfaction with food services. Two of the seven residents that expressed concern about food palatability eat their meals in their room, the other five eat their meals in the dining room. The residents (all three floors) stated, All meals are cold and sometimes don't come to the floor on time or sit in the hall for a while before being passed. The breakfast is the worse. If the food isn't cold, it's just not good. Three residents said the alternative such as a hamburger is (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	often dry, cold, and overcooked. The hot dogs are grey and shriveled up. The group said the food concerns have been brought to the attention of the facility multiple times and the food is getting worse. They also said there is supposed to be a food committee to discuss how to make the food better but has never happened.

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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 within reach for one (R15) of one resident reviewed for accommodation of needs, resulting in the delay in incontinence care and potentially other unmet care needs.Findings include:Findings include:On 1/13/2026 at 11:48 a.m. while in the hall of the fifth floor, a voice can be heard saying hello, hello, hello. Upon entering the room, R15 was observed facing the wall. R15 stated, I need help. I'm all wet (while patting backside). R15 was asked to reach and turn on the call light. R15 attempted to reach for the call light and could not be due to it not being within reach. The call light was observed on the nightstand tucked behind a towel, a stuffed animal, and other personal items.On 1/13/2026 at 11:51 a.m. LPN H approached the room and asked R15 what was needed. R15 stated, I'm all wet and need to be changed. LPN H was asked can R15 use the call light. LPN H looked for the call light and said they should have put the call light within reach after putting R15 to bed.On 1/16/26 at 12:30 a.m. the Director of Nursing (DON) was interviewed and acknowledged call lights should always be in reach for residents to use when they need help.Review of the clinical record documented R15 was initially admitted into the facility on 7/18/19 with diagnoses that included autistic disorder, epilepsy, schizoaffective disorder, depressive type, atherosclerosis of native arteries of extremities, bilateral legs, and legal blindness. According to the Minimum Data Set (MDS) dated [DATE], R15 was severely cognitively impaired (BIMS-3) and required extensive one-person assistance with activities of daily living.Review of the self-care performance care plan dated 8/5/25 documented in part: The resident (R15) has an activity of daily living self-care performance deficit related to dx of epilepsy, autistic disorder, schizophrenia, bipolar disorder, & legal blindness.prefers to have staff assist to the toilet. Intervention: .Toileting: Resident requires physical assistance x 1 staff with clothing and wiping during toileting and incontinence care. Encourage the resident to use bell to call for assistance.Review of the facility's policy titled Quality of Life -Accommodation of Needs dated 11/2013 documented in part: Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being. The resident's individual needs and preferences shall be accommodated to the extent possible.Review of the facility's policy titled Answering the Call Lights dated 11/2013 documented in part: . When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop, implement, or document an effective discharge plan of care for one (R222) of five residents reviewed for discharge planning resulting in the delay of home care services and potential delay for follow-up appointments for R222.Findings include: The State Agency received a complaint from R222 that they were not provided with sufficient information at the time of discharge regarding home health care services or follow-up appointments. On 1/14/26 at 1:08 PM R222 said, [NAME] set up home care for me when I left. It took a week after I was home before I could get ahold of anyone. The paper they gave me didn't have any phone numbers on it. I had to call the Social Worker several times before anyone could give me the right number for home care. R222 reported they were living in their home, followed up with their physician, and was receiving home care at this time. According to R222's electronic health record (EHR) the resident admitted to the facility on [DATE] with several diagnoses that included surgical repair of a fractured left femur after a fall at home, anxiety, and left eye blindness. R222 was discharged to their home on [DATE].A review of R222's care plans revealed there was no plan of care for discharge or post-discharge. There was no discharge summary.Progress notes from 9/17/25 - 10/23/25 were reviewed and did not reveal any discharge planning.On 9/17/25 a Social Work (SW) note documented the resident's discharge plan is to return to home. The next SW note dated 10/20/25 reads; Resident received a NOMNC (Notice of Medicare Non-Coverage) with LCD (Local Coverage of Determination) of 10/22/5. He will discharge home with HHC (Home Health Care).The final SW dated 10/23/25 documented the following: The resident was discharged to their home without DME (durable medical equipment) because they already have it at their home.R222's My Transition Home-Discharge form dated 10/22/25 at 3:42 PM was significantly incomplete. There was no phone number for the Home Health Care Agency. There was no information regarding the resident's follow-up appointments. The sections for; Contact information, Medication information, Nursing instructions, Dietary, and Discharge instructions were blank. On 1/15/26 at approximately 10:00 AM the Director of Social Services (SW) G reviewed R222's EHR and could not provide any documentation to support R222 had a discharge care plan or discharge planning. SW G acknowledged R222's 'Transition Home form was incomplete and did not include the HHC agency's phone number or any information regarding the resident's follow-up appointment. SW G said, The Home Health Care agency did not show up to the resident's home until 10/29/25 because they kept missing the calls. It was a week after the resident discharged and he called here because home care hadn't shown up. We called the (HHC) agency to work it out. I was told the resident had missed their (the HHC agency) calls and did not call them back. On 1/15/26 at approximately 11:00 AM the Director of Nursing (DON) reviewed R222's EHR and said, The transition form is incomplete. The Home Care agency was called by us and suppose to call the resident to set up visits, but the resident kept missing the agency's call. The resident did get their medications faxed to the pharmacy of their choice. I don't know why that information is not documented on the form or in medical record. The DON acknowledged the resident had no discharge care plan or discharge summary. A request for the facility's Discharge policy was requested. According to the facility's Transfer and Discharge Guideline last revised on 5/5/2025 in part reads; Discharge Planning ProcessResidents will be evaluated for their discharge goals, preferences, and care needs to meet their goals. The evaluation information will be used to develop a comprehensive discharge care plan. * The resident will be re-evaluated periodically to identify changes, and the discharge care plan will be modified to reflect any changes. The care plan will be developed by the interdisciplinary team, including the resident's physician, a registered nurse, other staff or professionals in disciplines determined by the resident's needs or requested by the resident, a member of the nutrition services staff and to the extent practicable, the resident and their (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative. The resident will be periodically reassessed to identify changes that require modification of the discharge plans and update the plans as needed The resident and representative will be provided with the final discharge care plan.A. Assessments and Discharge [NAME]. Upon admission to the facility and on an ongoing basis, resident will be evaluated based upon a comprehensive assessment and a person-centered discharge care plan will be initiated to address:i. Resident desires and choices1. Goals2. Treatment preferences3. Preference and feasibility for dischargei. Resident representative involvementii. Teaching with resident/resident representative and caregiver support needsiii. Medical condition/diagnoses1. Signs and symptoms2. When to notify a physician3. Laboratory/radiology testing and result explanationi. Medications and Treatments1. Reason for medications2. Common side effects3. Dose, time of day, duration, route4. Evidence of understanding/return demonstrationi. Functional and cognitive statuses and needs1. Resident specific ADLs2. Evidence of understanding/return demonstrationi. Advance Directivesii. Supplies and durable medical equipment (DME)iii. Follow-up appointments (including transportation)iv. Support Services for care following dischargev. Post discharge location (if known)vi. Risk factors for preventable re-hospitalization.C. Discharge .c. Update the resident's comprehensive care plan and discharge plan (if applicable) with any information received form referrals to local contact agencies or other appropriate entities.D. Documentationa. The resident needs and discharge plan must be documented in the medical record. If a discharge to the community is determined to not be feasible, document who made the determination and reason.b. The resident and resident representative will be informed of the final discharge plan. Proper Notice of Discharge will be provided according to the above guidance.c. An evaluation of the resident's discharge needs will be documented in the resident record on a timely basis. The results of this evaluation will be discussed with the resident or resident representative.d. Relevant resident information will be incorporated into the discharge plan to facilitate implementation and avoid unnecessary delays in resident discharge or transfer.e. The Discharge Care Plan as part of the comprehensive care plan and correlating documentation will be maintained in the medical record.D. Discharge SummaryA discharge summary will be completed upon discharge to include:a. Participation with the resident/resident representativeb. How facility will assist resident adjustment to new living environmentc. Details of where resident will resided. Post discharge follow-up detailse. Post discharge medical and non-medical servicesf. Information regarding how the location meets the resident's needs, provides needed support and resources, and meets the resident's preferencesg. A recapitulation of the residents stay in the facility (diagnoses, course of illness/treatment, therapy, lab, radiology and consultation reports)h. A recapitulation of resident's status.i. A reconciliation of resident's pre-discharge meds with post discharge meds

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete a discharge summary that included a recapitulation of stay for two (R12, R222) of five residents reviewed for discharge planning.Findings include:Resident 12 (R12): On 1/13/2026 at 11:29 AM R12 was seated in a wheelchair in the hallway and reported they were being discharged today. The resident said, I'm going to stay with my daughter for a little while. R12 was able to self-propel in her wheelchair independently. A review of the R12's Electronic Health Record (EHR) indicated the resident admitted on [DATE] with diagnoses that included cerebral infarction (stroke) affecting the dominate side and a fractured left humerus from a fall at home.R12's Recapitulation of Stay (Discharge Summary) form dated 1/13/2026 at 5:53 PM was incomplete. The Summary of Stay sections 1a-8 were blank. This included information for continuing care and/or special instructions or precautions for continuing care. The Additional Information section was also blank. This included contact information. Resident 222 (R222):On 1/14/26 at 1:08 PM R222 said, [NAME] set up home care for me when I left. It took a week after I was home before I could get ahold of anyone. The paper they gave me didn't have any phone numbers on it. I had to call the Social Worker several times before anyone could give me the right number for home care. R222 reported they were living in their home, followed up with their physician, and was receiving home care at this time. According to R222's electronic health record (EHR) the resident admitted to the facility on [DATE] with several diagnoses that included surgical repair of a fractured left femur after a fall at home, anxiety, and left eye blindness. R222 was discharged to their home on [DATE].There was no Recapitulation of Stay (Discharge Summary) form or discharge summary.R222's My Transition Home-Discharge form dated 10/22/25 at 3:42 PM was significantly incomplete. There was no phone number for the Home Health Care Agency. There was no information regarding the resident's follow-up appointments. The sections for; Contact information, Medication information, Nursing instructions, Dietary, and Discharge instructions were blank. On 1/15/26 at approximately 10:00 AM the Director of Social Services (SW) G reviewed R222's EHR and could not provide any documentation to support R222 had Recapitulation of Stay (Discharge Summary) form completed. On 1/15/26 at approximately 11:00 AM the Director of Nursing (DON) reviewed R222's EHR and said, There is no Recapitulation of Stay (Discharge Summary) form. The DON acknowledged the resident had no Recapitulation of Stay (Discharge Summary) form, discharge care plan or discharge summary. A request for the facility's Discharge policy was requested. According to the facility's Transfer and Discharge Guideline last revised on 5/5/2025 in part reads; Discharge Planning ProcessResidents will be evaluated for their discharge goals, preferences, and care needs to meet their goals.D. Discharge SummaryA discharge summary will be completed upon discharge to include g. A recapitulation of the residents stay in the facility (diagnoses, course of illness/treatment, therapy, lab, radiology and consultation reports)h. A recapitulation of resident's status.i. A reconciliation of resident's pre-discharge meds with post discharge medications.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for a foley catheter (indwelling urinary catheter) for one (R5) of three residents reviewed for catheter care resulting in the potential for inappropriate and ineffective care of the resident's indwelling catheter.Findings include: On 1/13/26 at 12:53 PM, R5 was observed lying in bed with foley catheter tubing hanging off the bed draining a small amount of amber urine into a collection bag. The collection bag had a privacy cover and was attached to the bed frame, below the level of the resident's bladder. The resident said there were problems with the foley catheter leaking urine last night. R5 said, There was urine all in my diaper and the bed. The CNA (certified nursing assistant) had to change my brief and the whole bed. The nurse came in and changed the bag. It seems to be working fine now. Upon further observation the catheter was not connected to an anchoring device. The catheter was pulled taut from the resident's penis through the leg hole of the brief hanging down from the bed. According to R5's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnoses that included Benign Prostrate Hypertrophy and Urinary Tract Infection (UTI). The Minimum Data Set, dated [DATE] indicated the resident had intact cognition. Section H documented R5 had an indwelling urinary catheter upon admission. On 10/21/25 the physician ordered foley catheter care every shift and to change the foley drainage bag every two weeks and prn (as needed). On 11/12/25 the physician ordered a urinalysis and culture and sensitivity test to be conducted. On 1/13/25 a review of R5's care plans revealed there was no care plan for a urinary catheter. On 1/14/25 at 10:40 AM during an interview with the Director of Nursing (DON)she said, There was no care plan until this morning. I noticed it when we were reviewing catheter issues last night and this morning. The MDS nurse was made aware of the oversight and corrected it. It was put in place earlier today. The DON acknowledged that the urinary care plan should have been initiated at the time of admission. A request for the facility's policy for care planning was made. According to the facility's Care plan Standard Guideline effective dated 11/18/2017 in part reads;GuidelineAll resident/client will be evaluated for individual risk factors which may increase the chance of hospitalization. Myocardial Infarction, Congestive Heart Failure, Pneumonia, Sepsis, and Urinary Tract Infection have been identified as high risk diagnoses, however, all potential conditions that could increase the chance of hospitalization should be identified for care planning needs. The resident care plan will incorporate risk factors identified in preadmission assessment, hospital records and admission evaluations, with changes in condition, reviewed and updated quarterly.Procedure1. The interdisciplinary team will collect and record data within 24 hours for the admission baseline Care Plan. Comprehensive Care planThe facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:1. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. DPS #2: Based on observation, interview, and record review the facility failed to develop a person-centered comprehensive dialysis care plan for one (R73) of one resident reviewed for dialysis resulting in inadequate care for a dialysis patient.Findings include:On 1/14/26 at 11:59 a.m. R73 was observed on the unit, in a wheelchair at the nurse's station. R73 was observed to be anxious and restless. R73 was shouting (at no one in particular). Staff attempted to redirect R73's behavior by attending to needs however R73 became more agitated and would not communicate what was needed. Staff were observed transporting R73 away from the nurse's station. While in the bedroom, R73 continued to display agitation but would not say what the cause was.On 1/16/26 at 8:10 a.m. R73 was observed by (continued on next page)

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Regency, A Villa Center	12575 S Telegraph Rd Taylor, MI 48180

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's entrance door (preparing to go to dialysis), as very angry and anxious. The Director of Nursing said R73 was upset because he didn't want to put shoes on to go to dialysis.A complaint was submitted to the State Agency reported by the dialysis center that R73 often arrives at dialysis very angry and anxious. It takes the dialysis staff a while (up to 40 minutes) to calm R73 down to administer the dialysis treatment. The dialysis staff have reported the behaviors to the facility multiple times and requested the facility to administer medications prior to R73 arriving to dialysis.Review of the clinical record documented R73 was initially admitted into the facility on 3/3/25 and readmitted on [DATE] with diagnoses that included end stage renal disease, dysphagia, dementia, psychotic disturbance, mood disturbance, and anxiety, and schizophrenia. According to the significant change Minimum Data Set assessment dated [DATE], R73 had severe impaired cognitive impairment (BIMS-6), unclear speech, and required one-two person assistance with most daily activities.Review of the Dialysis care plan dated 6/9/24 did not document person-centered goals or interventions to adequately address R73's dialysis needs. There was documentation the care plan problem and interventions were reviewed or revised since 6/9/24. Review of the facility's policy titled Care plan Standard Guideline dated 11/28/17 documented in part the following: All resident/client will be evaluated for individual risk factors which may increase the chance of hospitalization. The interdisciplinary team will continue develop a resident/client centered care plan that includes problem, need, or strength statements, measurable goal statements and resident/client specific interventions. The care plan is to be revised to reflect the current status of the resident. Interventions should be specific to reflect the specific goal. The intervention should be individualized to the resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement pressure ulcer care as prescribed for one (R5) of five residents reviewed for pressure ulcer care resulting in the potential for R5's pressure ulcer to worsen.Findings include:On 1/13/26 at 12:53 PM, R5 was observed lying in bed watching TV. During interview the resident said there were problems with the foley catheter leaking urine last night and the CNA (certified nursing assistant) did a complete brief and bed change. Further inquiry and observation revealed the resident was incontinent of stool. The resident said, Yes, my diaper needs to be changed again. It's soiled. I was waiting until after lunch to ask them to clean me up. At this time CNA L entered the room to remove the lunch trays and the resident requested care. During observation of incontinence care, R5's sacral area pressure ulcer was without a dressing covering it and directly open to a soiled brief. The pressure ulcer was clean, pink, moist, and without foul odor or drainage. CNA L said, Oh, this should be covered. I'll tell the nurse. At 1:05 PM Licensed Practical Nurse (LPN) M entered the room, observed R5's sacral pressure ulcer and said, Oh yeah, it needs to be covered. It must have not been replaced after the brief change on night shift. I'll let the wound care team know the dressing needs to be done. According to R5's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnoses that included Benign Prostrate Hypertrophy and Urinary Tract Infection (UTI). The Minimum Data Set, dated [DATE] indicated the resident had intact cognition and admitted to the facility with a stage 3 pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed.) A wound care note dated 10/3/25 measured the pressure ulcer at 3.8 centimeters (cm) length x 0.8 cm width x 0.30 depth. A care plan for 'sacral pressure ulcer' was initiated on 10/7/25 and included the following intervention: evaluate and treat per physician's orders. A physician's order dated 10/21/25 prescribed the following skin care treatments; [Activon] medi-honey to sacrum after normal saline/wound cleanser and cover with dry dressing every day shift and as needed for skin care. Triad past to periwound (around the wound). The wound care note dated 1/8/26 revealed the sacral pressure ulcer measured 3.7 cm length x 0.7 cm width x 0.3 depth. There were no progress notes for 1/13/26 during the evening or night shift. On 1/13/26 at approximately 2:00 PM wound care LPN D acknowledged that R5 did not have a dressing to the sacral area and should have been cleaned and dressed after incontinence care on the night shift. LPN D said, I'm not sure why the treatment was not done. Any nurse can and should re-do the dressing if it becomes soiled during incontinence. The orders are every day and as needed. The resident has been hospitalized for other medical issues causing a delay in healing. The wound is stable and has no signs of infection. On 1/14/25 at 10:40 AM during an interview with the Director of Nursing (DON) she said, The night shift nurse should have re-dressed the resident's pressure ulcer after incontinence care. The DON said that LPN B was assigned to R5 during the 1/13/26 night shift. No progress notes were documented on 1/13/26. The DON said there was a call to LPN B. A request for LPN B contact information and the facility's pressure ulcer care policy was requested. LPN B was unable to be interviewed during the survey. On 1/15/26 at 9:30 AM CNA A was interviewed via telephone. CNA A said, Yes, his (R5) catheter had leaked all in the brief and bed. I did a complete bed change. I think there was a dressing on his buttocks and I removed it. I did tell the nurse (LPN B) that his catheter needed to be looked at because it had leaked all in the brief and bed. I don't recall if I told her about the dressing. According to the facility's 'Skin Management Guideline' effective date 11/28/2017 reads in part. 11. When a pressure ulcer is present, daily wound monitoring should include: An evaluation of the ulcer, if no drainage is present An evaluation of the status of the dressing, if present The status of the area surrounding the ulcer (that can be observed without removing the dressing)

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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 provide appropriate indwelling urinary catheter (foley) care for one (R5) of three residents reviewed for catheter care.Findings Include: On 1/13/26 at 12:53 PM, R5 was observed lying in bed with foley catheter tubing hanging off the bed draining a small amount of amber urine into a collection bag. The collection bag had a privacy cover and was attached to the bed frame, below the level of the resident's bladder. The resident said there were problems with the foley catheter leaking urine last night. R5 said, There was urine all in my diaper and the bed. The CNA (certified nursing assistant) had to change my brief and the whole bed. The nurse came in and changed the bag. It seems to be working fine now. Upon further observation the catheter was not attached to an anchoring device to secure the catheter tubing to the resident's thigh. The catheter was pulled taut from the resident's penis through the leg hole of the brief hanging down from the bed. The resident was incontinent of stool.At approximately 1:00 PM CNA L entered the room to remove the lunch trays and R5 requested care. During observation of incontinence care, the CNA noted that R5's foley catheter did not have an anchoring device to stabilize the catheter and said, There should be a device that holds the foley to the thigh without pulling on it. I'll let the nurse know his is not on. At 1:05 PM Licensed Practical Nurse (LPN) M observed R5 during incontinence care and confirmed that the resident should have an anchoring device in place to secure the foley. LPN M went on to say, The catheter was leaking last night. The night shift nurse (LPN B) told me she changed the tubing and the bag. The anchoring device was probably removed because it was wet. I'll get another one. LPN M could not say what other actions the night shift nurse (LPN B) did for the resident's leaking foley catheter. She didn't say anything else. Just that she changed the bag. According to R5's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnoses that included Benign Prostrate Hypertrophy and Urinary Tract Infection (UTI). The Minimum Data Set, dated [DATE] indicated the resident had intact cognition. Section H documented R5 had an indwelling urinary catheter upon admission and was always incontinent. On 10/21/25 the physician ordered foley catheter care every shift and to change the foley drainage bag every two weeks and prn (as needed). On 1/13/26 a review of R5's care plans revealed there was no care plan for a foley (indwelling urinary) catheter. There were no progress notes on 1/13/2026 during the afternoon or night shift. There was no documentation to support R5's foley catheter had leaked, been provided with care, or the collection bag changed. On1/13/26 at approximately 11:00 AM the nurse unit manager, Registered Nurse (RN) C said she was aware that R5's foley catheter had leaked last night. She said, I talked to the night nurse about changing the resident's catheter bag because it was leaking. I talked her though the process of changing the collection bag. I don't believe the catheter was changed or irrigated. That was not discussed. At this time RN C reviewed R5's EHR and confirmed there was no documentation to support the foley catheter bag had been changed or that the resident's urinary output was assessed or monitored. There were no progress notes for R5 on 1/13/2026 during the night shift. On 1/14/2026 at 9:57 AM, R5 said he did not feel well and there was pain around his penis area. Observation of the resident's foley catheter revealed there was no urine in the collection tubing and very little urine in the collection bag. At this time LPN D was asked about R5's urinary status. LPN D entered the resident's room and confirmed there was no urine in the foley catheter tubing or collection bag, and the resident was complaining of discomfort. LPN D said, I'll notify the Nurse Practitioner. LPN D reviewed R5's EHR and confirmed there was no documentation to indicate that R5's foley catheter had leaked on 1/13/26. On 1/14/25 at 10:40 AM during an interview with the Director of Nursing (DON) she said she was aware of R5's catheter leaking after it was brought to her attention yesterday by RN C. The DON said she spoke with LPN B on the phone and confirmed the resident's foley catheter had leaked the night before (1/13/26) and the tubing and (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	collection bag were changed. There was no irrigation of the foley nor was the entire foley catheter changed. The DON acknowledged there was no documentation to support those actions or to indicate there was any further monitoring of the catheter or urine output. The DON said, She should have documented what occurred. Yes, there should have been an anchoring device for the resident's foley catheter. No, there was no care plan for the resident's foley catheter until today. It should have been initiated at time of admission. The DON reported that the Nurse Practitioner was made aware and the resident's urinary catheter was ordered to be changed along with a urinalysis. The DON was asked to provide the contact information for LPN B and the facility's policy for foley catheter care. On 1/15/26 at 9:30 AM CNA A was interviewed via phone and said, Yes, I cared for the resident on night shift 1/13/26. His bed was soaked with urine because the catheter was leaking. I did a complete brief and bed change. I told the nurse, but I don't know what she did because it was towards the end of the shift and I left. LPN B was unable to be interviewed during the survey. The facility's Urinary Indwelling Catheter Management Guideline effective date of 11/28/2017 reads in part:Indwelling catheters may be associated with significant complications, including bacteremia, febrile episodes, bladder stones, fistula formation, and erosion of the urethra, epididymitis, chronic renal inflammation and pyelonephritis Completion of a Bladder Observation will be complete upon admission and with a change in condition. The Bladder Observation will be reviewed quarterly and annually. When indwelling catheterization is recommended a Medical Necessity for Indwelling Catheters evaluation will be completed prior to urinary catheter intervention or upon admission with observation of an indwelling urinary catheter.Changing indwelling catheters and drainage bags at routine or fixed intervals is not recommended. Rather, catheters and drainage bags should be changed based on clinical indications such as: Infection Obstruction When the closed system is compromisedEnsuring the catheter is secured to eliminate dislodgement or irritation resulting from tension or pulling on the tubing. Developing a plan of care upon admission and / or placement that includes: o A review every quarterly, annually and with a change in condition, o Causal and or contributing factors;o Associated risks including infections;o Goals including trial removals if indicated;o Individualized interventions

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2711513.Based on interview and record review the facility failed to ensure correspondence between the facility and the dialysis center was implemented for one (R73) of one resident reviewed for dialysis resulting in missed communication for continuity in care. Findings include:On 1/14/26 at 11:59 a.m. R73 was observed on the unit, in a wheelchair at the nurse's station. R73 was observed to be anxious and restless. R73 was shouting (at no one in particular). Staff attempted to redirect R73's behavior by attending to needs however R73 became more agitated and would not communicate what was needed. Staff were observed transporting R73 away from the nurse's station. While in the bedroom, R73 continued to display agitation but would not say what the cause was. On 1/16/26 at 8:10 a.m. R73 was observed by the facility's entrance door (preparing to go to dialysis), as very angry and anxious. The Director of Nursing said R73 was upset to put on shoes and go to dialysis. A complaint was submitted to the State Agency reported by the dialysis center that R73 often arrives at dialysis very angry and anxious. It takes the dialysis staff a while (up to 40 minutes) to calm R73 down to administer the dialysis treatment. The dialysis staff have reported the behaviors to the facility multiple times and requested the facility to administer medications prior to R73 arriving to dialysis. The complaint noted RN I as the facility staff that was contacted about the R73's behavior while at dialysis. On 1/15/26 at 3:34 p.m. RN I was interviewed and said the antianxiety medication was not at the facility on 1/7/26 for R73 to take prior to going to dialysis. The medication could not be ordered in time and arrive at the facility before R73 went to dialysis. Although there was a physician order, a script was needed to order the medication through pharmacy or retrieve from the backup box. RN I was queried about the communication between the facility and the dialysis center. RN I said the telephone communication was not documented because the medication was ordered immediately. Review of the clinical record documented R73 was initially admitted into the facility on 3/3/25 and readmitted on [DATE] with diagnoses that included end stage renal disease, dysphagia, dementia, psychotic disturbance, mood disturbance, and anxiety, and schizophrenia. According to the significant change Minimum Data Set assessment dated [DATE], R73 had severe cognitive impairment (BIMS-6), unclear speech, and required one-two person assistance with most daily activities. R73 go to dialysis on Monday, Wednesday, and Friday with a chair time at 9am and pick up from the facility at 8am. Review of the Dialysis care plan dated 6/9/24 did not document person-centered goals or interventions to adequately address R73's dialysis needs. Review of the nurse's progress notes for 1/7/26 did not document the communication between the dialysis center and the facility. Review of the dialysis communication forms for the month of December and January documented the following in part:12/21/25- Completed by dialysis unit. Complications during visit: Agitation.1/2/26- Completed by dialysis unit. Complications during visit: Agitation.The communications for 1/5 (Monday), 1/7 (Wednesday), 1/9 (Friday) were not in the electronic medical record. On 1/16/25 at 8:33 a.m. the dialysis communication for the dates of 1/5, 1/7, and 1/9 were requested by the Director of Nursing (DON). The DON said they were not readily accessible and had to be found. The DON said documentation is an area that needs to be improved. On 1/16/26 at 11:23 a.m. the dialysis communication forms requested did not include the dates for 1/5, 1/7, and 1/9. On 1/21/26 at 9:21 a.m. the Dialysis Center Administrator N and the Dialysis RN O was interviewed via telephone and said the center is always calling the facility with concerns with R73 such receiving medications prior to arriving to dialysis or behavior. RN O said on 1/7/25 a call was placed to the facility regarding R73's behaviors. R73 was very agitated and angry. R73's behavior was distressing to both the resident and other patients in the clinic. R73 had been exhibiting behaviors for the last three weeks and the facility was notified both in writing using the communication form and telephone. The dialysis center does not keep copies of the communication forms sent back to the facility. Review of the facility's policy titled Clinical Guideline: Dialysis dated 1/2007 documented in part the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following: .Residents receiving hemodialysis are transported routinely out of the facility. Communication is essential for continuity of care. Communication between outpatient dialysis provider and facility should include Written communication form with review of daily weights, any changes in condition or mood. Be cognizant of medications ordered and timing of administration. Review Communication Folder for any pertinent information.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a functioning call light for one (R15) of one resident reviewed for environment resulting in unmet safety needs.Findings include:On 1/16/26 at 11:58 a.m. upon entering R15's bedroom, an unidentified resident was observed standing at the bedside, standing behind the wheelchair. R15 was then observed attempting to scoot to the edge of the bed and get into the wheelchair. The resident was asked what was occurring and the other resident stated, She wants to get up. The wheelchair wheels were not locked as the other resident stood behind the chair. The other resident was asked to put on the call light so staff can assist. The call light was observed activated while in the room. After several minutes of no staff response to the room, LPN H was observed at the end of the hall and asked to come to the room. The call light indicator that was located above the door of the bedroom was not illuminated. LPN H came to the room and redirected the other resident out of the room. LPN H attempted to activate the call light and the hall indicator would not come on. On 1/16/26 at 12:10 p.m. CNA K arrived at R15's bedroom to assist R15 into the wheelchair. CNA K attempted to activate the call light and stated, It comes on but you have to hold it down so it can stay on. When CNA K held the button down, the hall indicator remained on, but when released the hall indicator did not stay on. LPN H said they were unaware the call light was not working properly. Both LPN H and CNA K said the call light indicator at the nurse station was not heard and possibly not working properly. On 1/16/26 at 12:20 p.m. Maintenance Assistant J was interviewed with the Nursing Home Administrator (NHA) and Director of Nursing (DON) present. Maintenance Assistant J said they were not made aware of R15's call light not working. All bedroom call lights are checked twice a week and R15's call light could have broken that day. Maintenance Assistant J was unable to account for the last time R15's call light was checked. Review of the clinical record documented R15 was initially admitted into the facility on 7/18/19 with diagnoses that included autistic disorder, epilepsy, schizoaffective disorder, depressive type, atherosclerosis of native arteries of extremities, bilateral legs, and legal blindness. According to the Minimum Data Set (MDS) dated [DATE], R15 was severely cognitively impaired (BIMS-3) and required extensive one-person assistance with activities of daily living. Review of the self-care performance care plan dated 8/5/25 documented in part: The resident (R15) has an activity of daily living self-care performance deficit related to dx of epilepsy, autistic disorder, schizophrenia, bipolar disorder, & legal blindness.prefers to have staff assist to the toilet. Intervention: . Transfers: Resident requires physical assistance of 1 staff . Bed Mobility: assist x 1 staff to guide in bed and sitting to lying position.Encourage the resident to use bell to call for assistance. Review of the facility's policy titled Answering the Call Lights dated 11/2013 documented in part: Report all defective call lights to the nurse supervisor promptly. If assistance is needed when you enter the room, summon help by using the call signal.