

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Froh Community Home		STREET ADDRESS, CITY, STATE, ZIP CODE 307 N Franks Avenue Sturgis, MI 49091	
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 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 maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include: On 6/9/26 starting at 6:30 AM, an initial tour of the kitchen was performed with Dietary Manager (DM) K. On 6/9/26 at 6:44 AM, observation of the produce and preparation walk in cooler found a large three-gallon stock pot labeled sweet potato soup. The item was found covered in plastic wrap, with noticeable condensation on the inside top. When asked when this item was prepared, DM K stated it was made last evening and cooled down with an ice wand. When asked what temperature the soup should be at this time, DM K stated it should be at 41F or below. The surveyor measured the temperature of the soup with a digital rapid read thermometer and found it to be 70F in the center. When asked what should be done with the soup, DM K stated it needed to be dumped. When asked to see if this item was on the cooling log, DM K stated it did not make it on the cooling log. On 6/9/26 at 7:07 AM, observation of the clean utensil drawer containing metal spoons found an increase in accumulation of crumb debris in a line on the back of the drawer. When asked how often this area gets cleaned, DM K stated weekly. On 6/9/26 at 7:08 AM, observation of the can opener found a dried sticky red substance on the blade of the opener with sticky debris lining the bar of the can opener as it was pulled from the holder. On 6/9/26 at 7:13 AM, observation of the kitchen microwave found an accumulation of dried debris on the inside ceiling of the unit. On 6/9/26 at 7:21 AM, observation under the back preparation table found two open containers of less sodium soy sauce, one bottle almost empty and the other still full. A review of the manufacturer's directions state to Refrigerate After Opening. On 6/9/26 at 7:24 AM, observation of the inside of the dish machine found black and brown slimy accumulation hanging out of the holes of the rinse sprayer arm. When asked how often the unit gets cleaned on the inside, DM K stated it gets delimed monthly. On 6/9/26 at 12:07 PM, a revisit to the produce and preparation walk in cooler found a large container labeled shepherd's pie, covered tightly with plastic wrap, sitting on ice. When asked what the item was for, DM K stated it was cooling for lunch the next day. At this time, the temperature of the product was taken and found to be 110F. A check of the cooling log did not find evidence that this item was being tracked. According to the 2022 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. According to the 2022 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3) Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling. TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above. (2) At 5C (41F) or less. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received annual Level 1 PASARR (Pre-admission Screening and Resident Review) and follow up Level II PASARR to ensure appropriate mental health services were provided for 5 residents (Resident #10, Resident #17, Resident #20, Resident #48, Resident #8) of 5 residents reviewed for PASARR resulting in the potential for residents to not receive appropriate mental health treatment and services and residents to be inappropriately placed in the nursing facility . Findings include: Resident #10 (R10) Review of the Facesheet and Minimum Data Set (MDS) dated [DATE] revealed R10 admitted to the facility on [DATE] with pertinent diagnoses including severe dementia with agitation (decline in mental ability that interferes with daily life and leads to excessive motor activity, verbal aggression, or physical aggression that causes severe distress), psychotic disorder with delusions (mental health condition characterized by a break from reality despite clear evidence to the contrary), depression, anxiety and unspecified intellectual disabilities. Brief Interview for Mental Status (BIMS) reflected a score of 8 out of 15 which indicated R10's cognition was moderately impaired. During an interview on 6/9/2026 at 9:18 PM, R10 asked this surveyor questions and kept mumbling this surveyor's name throughout the conversation. When this surveyor left R10's room, he yelled this surveyor's name multiple times and it could be heard down the hallway. Review of R10's PASARR level I screening dated 4/9/2025 under Section II-Screening Criteria revealed that yes was marked for the following questions: The person has a current diagnosis of mental illness; The person has received treatment for mental illness; The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days; There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others; The person has a diagnosis of an intellectual disability or a related condition including, but not limited to, epilepsy (neurological disorder that causes seizures), autism (neurodevelopmental condition that affects how individuals communicate, interact, behave and perceive the world), or cerebral palsy (neurological disorder that affects a person's ability to move and maintain balance and posture) and this diagnosis manifested before the age of 22. Under Explain any Yes (questions): Previously received ID/DD (Intellectual Disability/Developmental Disability) services from (name omitted) and had lived in a group home; Zoloft 100 mg (milligrams), depression, increased 10/11/24, xanax (for anxiety) .5 milligrams tid 11/22/24, Risperdal 2 mg hs (evening), failed GDR (Gradual Dose Reduction) 8/2/24, able to express basic needs and has limited reasoning skills. The form indicated If any answers to items 1-6 in Section II is yes, send ONE copy to the local Community Mental Health Service Program (CMHSP). so a level II PASARR could be completed. Further review of R10's chart revealed that there was no annual level I PASARR and follow-up level II PASARR after 4/9/2025 and as of 6/9/2026 at the start of the survey. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/2026 at 9:03 AM, Social Service Director (SSD) C stated that he would look into where R10's level I and level II PASARR documentation was. During an interview on 6/10/2026 at 9:05 AM, Director of Nursing (DON) B reported that the facility completed the level I PASARR screenings and then Community Mental Health (CMH) did the level II PASARRs. DON B stated that she would look for R10's level I and level II documentation since it should have been completed. During a follow up interview on 6/11/2026 at 10:41 AM, DON B stated that the previous SSD left on 8/15/2025 and then SSD C started on 9/22/2025. DON B said that she thought SSD C completed the level I PASARR screenings and sent the documentation to CMH so they could complete the level II PASARR. DON B said that she thought SSD C was doing the level I PASARR and didn't realize he wasn't a licensed social worker and couldn't do them. DON B reported that the level I PASARR screenings and the documentation being sent to CMH to have a level II PASARR completed were not being done since the former social worker left on 8/15/2025 and she was unsure of how many residents were missed. Review of PASARR Policy with a review date of 3/11/2025 revealed .I. Goal: To ensure that individuals with mental illness/intellectual/developmental disabilities/related conditions receive the care and services that they need in the most appropriate settings. The PASARR will be evaluated annually and upon any significant change for those individuals identified. R17 According to the Minimum Data Set (MDS) dated [DATE], R17 scored 15/15 on his BIMS (Brief Interview Mental Status) indicating he was cognitively intact with active diagnoses within 7 days of the assessment included bipolar disorder (a mental health condition that causes extreme, cyclical shifts in mood, energy, activity levels, and concentration). Section N-Medications indicated the high-risk drug classes R17 were taking included antipsychotics and anticonvulsants. Review of R17's Form-3877 Level 1 Screening PASARR dated 6/14/25 revealed in Section II, the resident had a current diagnosis of mental illness, received treatment for the mental illness including routinely receiving one or more prescribed antipsychotic or antidepressant medications within the last 14-days. It did not indicate R17 had a diagnosis of dementia (a group of symptoms including memory loss, confusion, and impaired reasoning that interfered with daily life). Review of the Form-3877 Preadmission Screening (PAS)/Annual Resident Review (ARR) indicated Sections II (Screening Criteria) and Section III (Clinician's Statement) must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner, or a physician. In any answer to items 1-6 in Section II were Yes, one copy of the Form-3877 must be sent to the local Community Mental Health Services Program with a copy of Form-3878 (Level II Screening) if an exemption is requested. The nursing facility must retain the original in the resident's record. Review of R17's medical records revealed the resident did not have a 2026 annual Form-3877 Level I Screening as of 6/10/26 at 12:00 PM. Review of R17's medical records did not have a copy of Form-3878 Level II Screening in his medical (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	records completed by a community mental health program. The Form-3878 Level II Screening process serves to 1. Confirm Diagnoses: Identify or verify if an individual has a serious mental illness (MI), intellectual disability (ID), or a related condition. 2. Evaluate Placement: Determine if the patient actually requires the high level of care provided in a nursing facility. 3. Identify Specialized Needs: Assess whether the individual requires specialized or rehabilitative mental health services during their nursing home stay. Review of R17's Care Plan (a treatment plan for comprehensive resident-specific needs) did not have a focus for PASARR/OBRA/Level Screening and mental health needs to assist the resident. During an interview on 6/10/26 at 12:01 PM, Social Services (SS) C stated, I am not a licensed social worker and cannot complete the Level I Screening for OBRA (Omnibus Budget Reconciliation Act of 1987 that established sweeping national minimum standards of care and a [NAME] of Rights for residents in nursing homes and long-term care). The facility's Director of Nursing (DON) is doing the resident's Level I screenings. (Name of community mental health agency) is doing Level II Screenings. I started working at the facility in September 2025. During an interview on 6/10/26 at 12:03 PM, DON B stated, I thought (SS C) could complete the OBRA forms for Level I Screening. (SS C) thought (name of mental health services agency) could do them. When (SS C) was hired in September 2025 I knew he was not licensed and he could not complete the OBRA Level I Screening forms. R20 According to the Minimum Data Set (MDS) dated [DATE], R20 scored 10/15 on her BIMS (Brief Interview Mental Status) indicating she was cognitively impaired with active diagnoses within 7 days of the assessment that included non-Alzheimer's dementia (an umbrella term for various brain disorders that cause cognitive and behavioral decline severe enough to disrupt daily life, but are not caused by the specific protein build-ups (amyloid plaques and [NAME] tangles) of Alzheimer's disease). Review of R20's Form-3877 PASARR Level 1 Screening dated 5/12/25 indicated the resident was diagnosed with MI (mental illness) and Dem (dementia). Review of R20 medical records did not reveal a Form-3877 PASAR Level I Screening had been completed for 2026 as of 6/9/26 the start of the recertification survey. Review of R20's Form- 3878 Level II Screening dated 5/12/2025, did not indicate it had been sent to the community mental health agency for Level II screening. Review of R20's Care Plan did not have a focus for PASARR/OBRA/Level Screening and mental health needs to assist the resident. R48 (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Minimum Data Set (MDS) dated [DATE], R48 scored 1/15 on her BIMS (Brief Interview Mental Status) indicating she was severely cognitively impaired. Active diagnoses within 7 days of the assessment included non-Alzheimer's dementia, anxiety disorder (emotion characterized by feelings of tension, worried thoughts, and physical changes like a racing heart), depression (a serious mood disorder characterized by persistent feelings of sadness, hopelessness, and a loss of interest in activities), Schizophrenia (a chronic and severe brain disorder), Schizoaffective disorder bipolar type (a chronic mental health condition where a person experiences symptoms of schizophrenia (like delusions or hallucinations) alongside severe mood swings characteristic of bipolar disorder (manic episodes and sometimes major depression), and borderline personality disorder (a mental health condition characterized by severe instability in emotions, self-image, and behavior). Section N-Medications indicated the high-risk drug classes R48 were taking included antipsychotics, antidepressants, and anticonvulsants. Review of R48's OBRA Form-3878 Level II Screening dated 2/27/25 revealed reevaluation was required in 363 days due to a change in condition. Further review of R48's medical records did not reveal OBRA Form-3878 Level II Screening had been completed within 363 days. R8 According to the Minimum Data Set (MDS) dated [DATE], R8 scored 12/15 on her BIMS (Brief Interview Mental Status) indicating she was moderately cognitively impaired. Active diagnoses within 7 days of the assessment included non-Alzheimer's dementia, and Schizophrenia. Section N-Medications indicated the high-risk drug classes R8 included antidepressants medications. Review of R8's Form- 3877 Level I Screening, dated 3/14/25, indicated the resident had a mental health illness and dementia. Further review of R8's medical records did not reveal an OBRA Form-3878 Level II Screening had been completed for 2025. Review of R8's medical records did not reveal Form-3877 Level I Screening had been completed for 2025. Review of R8's Care Plan did not have a focus for PASARR/OBRA/Level Screening and mental health needs to assist the resident.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure psychotropic medications (prescription drugs that alter brain chemistry to affect mood, thoughts, behavior and perception) were not prescribed and administered without a medical indication for use for 1 (Resident #4) of 6 residents reviewed for chemical restraints, resulting in the potential for a resident to receive psychotropic medications unnecessarily. Findings include: Review of a Psychotropic Medication Policy and Procedure with a reference date of 3/11/25 revealed It is the policy of (facility name omitted) that the Geriatric Psychiatrist and the Primary Care physician will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring, is done. IV. Procedures: Orders for psychotropic medication only for the treatment of specific medical and/or psychiatric conditions. 2. Document rationale and diagnosis for use and identify target symptoms. Resident #4 Review of a Face Sheet revealed Resident #4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: generalized anxiety disorder (persistent, excessive, and uncontrolled worry about everyday topics) and insomnia (persistent difficulty falling asleep, staying asleep, or waking up too early and being unable to return to sleep). Review of a Minimum Data Set (MDS) assessment for Resident #4 with a reference date of 5/22/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 10/15, which indicated the resident was moderately cognitively impaired. Review of a Care Plan for Resident #4, completed by Director of Nursing (DON) B, with a reference date of 9/12/24, revealed the following problem/goal/approaches: Problem: I receive psychotropic medication for insomnia/mood. Anxiolytic (anti-anxiety medication) was discontinued then added back on 11/8/25. Goal: I will be prescribed the lowest effective dose of medication. Approaches: assess if the resident's behavioral/mood symptoms present a danger to the resident and/or others, assess/record effectiveness of drug treatment. Review of Physician Orders for Resident #4 with a reference date of 11/7/25 revealed Start date: 11/8/25, lorazepam (prescription medication belonging in the benzodiazepine class)-Schedule IV (prescribed drug class subject to strict regulations) tablet; 0.5 mg (milligrams), amt (amount): 0.25 mg; oral at bedtime. Diagnosis: (no information provided). In an interview on 6/10/26 at 2:55pm, Social Worker (SW) C confirmed Resident #4's order for lorazepam did not include a diagnosis and rationale for its use from the physician. SW C reported he monitored the use of psychotropic medications and ensured the medications were prescribed based on a clinical rationale and diagnosis, but this order had not been reviewed. In an interview on 6/11/26 at 12:23pm, DON B confirmed that she reviewed Resident #4's electronic medical record (EMR), and it did not include physician documentation of a clinical rationale and diagnosis related to the order for lorazepam that was initiated on 11/8/25.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide individualized activities designed to meet the interests and support the mental and psychosocial well-being of 1 (Resident #9) of 1 resident reviewed for activities, resulting in boredom, decreased mental stimulation and decreased satisfaction with personal leisure lifestyle. Findings include: Review of Participating in Activities You Enjoy as You Age, published by the National Institute on Aging, 3/28/22, revealed: Research has shown that older adults with an active lifestyle: .Are less likely to develop certain diseases. Participating in hobbies and other social activities may lower risk for developing some health problems, including dementia, heart disease, stroke, and some types of cancer. Studies looking at people's outlooks and how long they live show that happiness, life satisfaction, and a sense of purpose are all linked to living longer. Doing things that you enjoy may help cultivate those positive feelings. Studies suggest that older adults who participate in activities they find meaningful, .say they feel happier and healthier. When people feel happier and healthier, they are more likely to be resilient, which is our ability to bounce back and recover from difficult situations. Positive emotions, optimism, physical and mental health, and a sense of purpose are all associated with resilience.research suggests that participating in certain activities, such as those that are mentally stimulating or involve physical activity, may have a positive effect on memory- and the more variety the better.Resident #9Review of a Face Sheet Resident #9 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: hypertensive retinopathy (eye damage caused by high blood pressure) and major depressive disorder (a serious mood disorder characterized by intense, persistent feelings of sadness, hopelessness, and loss of interest in daily activities). Section D of the MDS revealed Resident #9 reported she felt down, depressed, or hopeless during 7-11 days of the 14-day assessment period.Review of a Minimum Data Set(MDS) assessment for Resident# with a reference date of 3/27/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 14/15, which indicated the resident was cognitively intact. Section D of the MDS revealed Resident #9 reported she felt down, depressed, or hopeless during 7-11 days of the 14-day assessment period.Review of a Care Plan for Resident #9 with a reference date of 3/23/26 revealed the following problem/goal/approaches: (Resident #9) is an independent woman and likes to do her own activities.she likes to read.Goal: I will accept items from the media cart as I have need. Approaches.having reading material is important to me. I will review what is offered on the media cart. Staff will offer items from the media cart and remind (Resident #9) of the library in the Gathering place.Review of the most recent Activities Assessment for Resident #9 with a reference date of 6/29/25 revealed Section 3-Psychosocial Well-being, changes in physical, cognitive and/or emotional status: mood fluctuation .Section 4-Activity Participation: She likes both independent and group activities .reading . Review of a Doctor of Optometry Visit Note for Resident #9 with a reference date of 3/26/26 revealed Chief Complaints: 1. Painless and Progressive Visual Loss. This is a [AGE] year-old female who is being seen for . painless and progressive visual loss involving the right eye and left eye. The symptoms are associated with blurred vision, difficulty reading, and difficulty seeing TV.During an observation on 6/9/26 at 11:24am. Resident #9 sat in her wheelchair in her room, unengaged and did not initiate interaction without encouragement.In an interview on 6/9/26 at 11:26am, Resident #9 reported she often felt bored and wanted to have more mental stimulation. Resident #5 reported she used to love to read but could no longer see well enough to do so and she felt unhappy with the opportunities she had for leisure involvement. Resident #5 reported she wanted (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be involved in activities that would stimulate her mind but due to her vision, did not feel she could pursue independent activities for mental stimulation anymore. Resident #5 reported she had not been presented with any adaptive options that might improve her abilities to pursue reading such as large print materials or talking books. In an interview on 6/10/26 at 11:19am, Certified Nursing Assistant (CNA) BB reported she regularly cared for Resident #9. CNA BB reported Resident #9 complained of feeling bored in recent months. CNA BB reported she encouraged Resident #9 to read because the resident loved it but had observed that it appeared Resident #9 could no longer read. CNA BB stated She'll look at a book for a little while, but I don't think she can actually read now. In an interview on 6/11/26 at 11:19am, Activities Director (AD) DD it was important for her to be aware of each resident's likes, dislikes, and abilities to ensure individualized activities were provided to meet their needs. When queried regarding Resident #9's current leisure interests, AD DD stated She reads a lot. AD DD reported she only completed leisure assessments with residents upon their admission to the facility because she did not have time to complete follow up assessments. AD DD reported she was not aware of any changes in Resident #5's ability to read or that the resident complained of feeling bored and wanted more mental stimulation. AD DD reported she tried to check in with residents to see if their leisure needs had changed but she did not do so on a scheduled basis and was not always involved in care conference meetings where she could receive feedback from residents and their family members. AD DD reported if she had known about the decline in Resident #5's vision, she would could have attempted new interventions such as offering to have someone read to her or assisting Resident #9 with enrolling in a talking book program. Review of a Activity Department policy with a reference date of 6/18/21 revealed Mission Statement: It is the mission of this Activity Department to provide all residents with a meaningful and interesting program of activities to promote the physical, mental and psychosocial well being of each individual resident. Review of a Activities Director job description with a reference date of 9/28/17 revealed Primary Purpose.2. Assist each resident to reach their maximum potential for social, psychological, mental, and spiritual well-being through varied types and levels of activities. Job Responsibilities.2. Evaluate each resident. and develop a plan of care, goals and the process by which objectives are met. 3. Review and evaluate each nursing center resident on quarterly basis. 6. Be alert to any change in condition of residents. 8. Evaluate activities. Adapt, terminate, or create new activities to meet the needs of the residents.		

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure effective pain medication was provided prior to wound care treatments for 1 (Resident #4) of 1 resident reviewed for pain management, resulting in 1. Resident #4 undergoing wound measurements and dressing changes without his requested pain medication. 2. Resident #4 grimacing, verbalizing pain and expressing frustration that he did not receive the pain medication he requested. Findings include: Resident #4 Review of a ?Face Sheet revealed Resident #4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: venous insufficiency (condition causing poor blood circulation) and non-pressure chronic ulcers of right lower leg (wound(s) caused by poor circulation). Review of a Minimum Data Set (MDS) assessment for Resident #4 with a reference date of 5/22/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 10/15, which indicated the resident was moderately cognitively impaired. Section B revealed Resident #4 always understood others and made himself understood. Section J of the MDS revealed Resident #4 reported he experienced pain frequently. Review of a Care Plan for Resident # 4 with a reference date of 10/17/24 revealed the following problem/goal/approaches: 1. (Resident #4) .has stasis ulcers (open wounds caused by poor circulation) on right leg and heel. Goal: Wound will be free of infection. Approaches: .perform treatments per physician order. 2. (Resident #4) has a potential for pain due to peripheral vascular disease (narrowing of blood vessels causing reduced circulation of blood) .Goal: (Resident #4) will be comfortable through next review. Approaches. staff will anticipate need for pain relief. Instruct/remind resident to request medication before pain becomes too great. During an observation and interview on 6/9/26 at 9:59am, Licensed Practical Nurse (LPN) W reported she was the acting wound nurse for the day and was about to begin wound care on Resident #4's stasis wounds on his right lower leg. LPN W removed the bandage from a wound on Resident #4's right anterior (front) shin and cleaned the wound with gauze saturated with normal saline (sterile mixture of 0.9% sodium chloride (salt) in water). Resident #4 grimaced in pain as the gauze lightly touched the open surface of the wound. LPN W continued the wound care and as she measured the width, length and depth of the stasis wound on Resident #4's right heel, the resident grimaced, stated Ow, that hurts. I asked for acetaminophen (brand name removed) and the pill never arrived today Resident #4 held breath and grimaced for a few seconds after the statement. In an interview on 6/9/26 at 9:59am, LPN W confirmed she did not check to see if Resident #4 had received his pain medications prior to completing wound care for him on this date. Upon reviewing Resident #4's medical record, LPN W reported the resident had not received the acetaminophen he requested prior to the completion of wound care. LPN W reported Resident #4 also had an order for gabapentin (nerve pain medication) but she had not checked to ensure he received it prior to completing his wound care. In an interview on 6/9/26 at 10:03am, Resident #4 reported the wound care had been painful on this date and he wanted to have acetaminophen prior to his wound care, so he asked for it earlier, but it was not provided. In an interview on 6/10/26 at 1:29pm, LPN V, the floor nurse caring for Resident #4 on 6/9/26, reported the nurse should always ensure a resident received any prescribed pain medication prior to completing wound care because doing so would avoid the resident experiencing any avoidable discomfort. LPN V reported she administered acetaminophen to Resident #4 at approximately 11:00am on 6/9/26. Of note, the medication was provided after the resident's wound care was completed. Review of Physician Orders for Resident #4 revealed 1. Acetaminophen tablet; 500mg (milligrams) every 6 hours-PRN (as needed), start date 10/13/25. 2. Gabapentin capsule; (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	400mg; amt(amount); one; oral (by mouth) three times a day, start date 2/20/26. 3. Cleanse right heel with NS (normal saline), pat dry, apply Calcium alginate (naturally occurring cream-colored, gel-like substance) cover with 4x4 gauze and secure with bordered gauze. Daily and PRN, start date 5/1/26. 3. Cleanse right leg with NS, pat dry, apply calcium alginate cover with 4x4 gauze and secure with bordered gauze. Daily and PRN, start date 5/1/26. Review of a Medication Administration Record for Resident #4 revealed the resident received acetaminophen 500mg at 10:08am on 6/9/26. Further review revealed Resident #4 rated his pain level at a 6 (moderate pain) on the Numeric Comparative Rating Scale (NRS) pain scale (0-10, 10 being the worst pain imaginable). Resident #4 had not received the medication in the previous 24 hours/was eligible to receive it when it was requested. Review of a Nursing Progress Note for Resident #4 with a reference date of 6/9/26 at 11:54am, revealed Resident reported pain with wound care. New order noted; ask resident if he would like (name brand omitted) acetaminophen for pain prior to dressing change. In an interview on 6/11/26 at 1:00pm, Director of Nursing (DON) B reported per professional standards of practice, the nurse should ensure a resident received prescribed pain medication and that the medication was effective prior to the completion of wound care. Review of Fundamentals of Nursing E-Book (Kindle Locations 61535-61556) Elsevier Health Sciences, Kindle Edition, [NAME], [NAME], [NAME], Stockert, Hall, revealed Pain is a universal but individual experience and a condition that nurses encounter among patients in all settings. It is the most common reason that people seek health care; yet it is often underrecognized, misunderstood, and inadequately treated. A person in pain often feels distress or suffering and seeks relief. Pain management should be patient centered, with nurses practicing patient advocacy. Effective communication among the patient and professional caregivers is essential to achieve adequate pain management. Review of a Pain Management policy with a reference date of 8/21/23 revealed GOAL: It the policy of (facility name omitted) to provide an effective systemic approach to recognize, assess, treat and monitor pain, through processes that identify potential barriers while creating a person-centered plan.		