STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235350	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gaylord	508 Random Lake Gaylord, MI 49735

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 store, prepare, and serve food in accordance with professional standards for food service safety for all 70 residents living in the facility. Findings include: During a tour of the dietary department with Registered Dietitian (RD) A and Dietary Manager (DM) Q on 3/17/2026 at 12:18 PM, the following items were noted in the reach in freezer:an opened unsealed plastic bag in a manufacturer's box with beef patties exposed to air, and undated as to opened date and use by (expiration) datea partial bag of frozen formed cookie dough unlabeled and undated as to opened date and use by datea partial bag of frozen premade biscuits unlabeled and undated as to opened date and use by date.a partial bag of frozen hashbrowns unlabeled and undated as to opened date and use by date.The reach-in refrigerator contained an opened thickened apple juice with an opened date of 1/28 and a use by date of 2/3.On 3/17/2026 at 12:49 PM, a tour of the pantry on C Hall with RD A and DM Q, revealed a refrigerator containing an opened quart container of honey thickened orange juice without an opened date, but with a use by date of 2/24/26 and an opened quart container of nectar thickened cranberry juice with an opened date of 2/16 and no use by date.On 3/17/2026 at approximately 1:00 PM, a tour of the pantry on C Hall with RD A and DM Q, revealed a refrigerator with an opened quart container of thickened cranberry juice which was not marked with an opened date or use by date.On 3/18/2026 at 7:33 AM, the reach-in refrigerator in the dietary department was observed to include two containers of honey thickened milk. Each of these quart sized containers were marked as opened 3/10/26 and use by 3/16/26, two days prior. The container included instructions printed on the side which indicated the product must be used within four days of opening, which was four days prior to this observation.The facility provided their policy titled, Food Receiving and Storage dated as reviewed and revised 7/1/2025 which read in part, . 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (opened on and use by date).According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat,Time/Temperature Control for Safety Food, Date Marking. (A) Except whenPACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specifiedunder S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated,READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD preparedand held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly markedto indicate the date or day by which the FOOD shall be consumed on the PREMISES,sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E)-(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FORSAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANTshall be clearly marked, at the time the original container is opened in a FOODESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the dateor day by which the FOOD shall be consumed on the PREMISES, sold, or discarded,based on the temperature and time combinations specified in (A) of this section and:(1) The day the original container is opened in the FOOD ESTABLISHMENT shall becounted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENTmay not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety .On 3/18/25 at approximately (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7:40 AM, the sanitizer bucket containing a wiping cloth floating in the solution in the dietary department was tested for sanitizer concentration. The dietary staff member P stated the bucket contained bleach water. RD A tested the solution, and it measured zero parts chlorine indicating the solution contained no sanitizer.3-304.14 Wiping Cloths, Use Limitation. (A) Cloths in-use for wiping FOOD spills from TABLEWARE and carry-out containers that occur as FOOD is being served shall be: (1) Maintained dry; and (2) Used for no other purpose. (B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114; and. Wiping Cloths, Use Limitation. Soiled wiping cloths, especially when moist, can become breeding grounds for pathogens that could be transferred to food. Any wiping cloths that are not dry (except those used once and then laundered) must be stored in a sanitizer solution of adequate concentration between uses. Wiping cloths soiled with organic material can overcome the effectiveness of, and neutralize, the sanitizer. The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure correct implementation of transmission-based precautions (TBP) for one Resident (#87) of one resident reviewed for TBP and to ensure infection prevention and control policies were reviewed on an annual basis with the potential to affect all 70 residents living in the facility.Findings include:Resident #87 (R87) Review of the electronic medical record (EMR) revealed R87 was admitted to the facility on [DATE] and had diagnoses including sepsis due to methicillin susceptible staphylococcus aureus (MSSA) and osteomyelitis of the left ankle and foot. On 3/17/2026 at 1:42 p.m. R87 was observed self-propelling in a wheelchair toward his room from the entry of D-Hall, near the nurses' station. R87 was not wearing a protective gown. Upon observing R87 enter his room, it was noted there was a Center for Disease Control and Prevention (CDC) Contact Precaution sign adhered to the front of R87's door and a cart containing personal protective equipment (PPE) positioned in the hall next to the Resident's doorway. Further review of the CDC Contact Precaution sign revealed the following: Stop. Contact Precautions. Everyone Must . put on gloves before room entry . Put on gown before room entry . On 3/17/2026 at 2:33 PM, Licensed Practical Nurse (LPN) S was observed preparing R87's medications for administration and was accompanied to the Resident's room. Upon entering R87's doorway, LPN S was asked if a protective gown and gloves was required to enter R87's room. LPN S stated, No, he can come out of his room now. That was from before. LPN S entered R87's room without donning a protective gown or gloves. It was noted the CDC Contact Precautions sign remained adhered to the door of R87's room at the time of the observation. LPN S proceeded to prepay R87's intravenous antibiotic for administration, assisted R87 to lay down in bed per his request, and assisted the Resident to remove his long-sleeved sweatshirt. R87 was observed to have a right upper arm PICC line. LPN S cleansed the port of R87's PICC line, flushed the line and attached the IV tubing to administer the Resident's medication. LPN S did not wear a protective gown while caring for R87's PICC line. An observation on 3/19/2026 at 9:14 AM revealed the CDC Contact Precaution sign remained adhered to R87's door and the PPE supplies were in hall next to the Resident's doorway. During an interview outside R87's room on 3/19/2026 at 10:55 AM Certified Nursing Assistant (CNA) T explained the Contact Precaution sign adhered to R87's door was, Because he has an IV and wounds on his foot. CNA T reported she gowned up when performing close contact care activities with R87. CNA T was asked what the difference between Contact Precautions and Enhanced Barrier Precautions (EBP). CNA S reported she considered the utilization of Contact Precautions was to be used as EBP. During an interview on 3/19/2026 at 11:05 AM, the facility's Infection Preventionist, Registered Nurse (RN) N was queried regarding the status of R87's infection and requirement for TBP. RN N stated R87 was placed in Contact Precautions due to, An infection in his spine. RN N reported staff were to wear a protective gown and gloves when providing high-contact care activities. When asked to explain the differences in Contact Precautions and EBP, RN N replied, They're basically the same. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Transmission-Based Precautions, with a review date of 12/31/2025, revealed the following: The facility will use standard approaches, as defined by the CDC, for transmission-based precautions: airborne, contact and droplet precautions . Residents on transmission-based precautions should remain in their rooms except for medically necessary care . Contact Precautions: Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for interactions that may involve contact with the residents or potentially contaminated areas in the resident's environment . Gloves: Whenever touching the patient's intact skin or surfaces and article in close proximity to the patient. [NAME] gloves upon entry into the room . Gowns: Whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environment surfaces or equipment in close proximity to the patient. [NAME] gown upon entry int the room . Review of the facility policy titled, Enhanced Barrier Precautions, with a review date on 3/26/2024, revealed the following: Enhanced Barrier Precautions refer to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and gloves use during high-contact resident care activities . High-contact care activities to consider include . dressing . device care or use: central lines . On 3/19/26 at 11:15 AM, an interview was conducted with Infection Preventionist (IP) N who verified responsibility for the Infection Prevention and Control Program (IPCP) and associated policies. IP N stated the following infection control policies had not been updated annually: Infection Prevention and Control Program: last revised/reviewed on 12/27/23. Infection Surveillance: last revised/reviewed 10/26/23. Antibiotic Stewardship Program: last revised/reviewed 12/13/23. Influenza Vaccination: last revised/reviewed 10/26/23. Pneumococcal Vaccine (Series): last revised/reviewed 10/30/23. On 3/19/26 at 12:02 PM, the Nursing Home Administrator (NHA) confirmed the IPCP policies were the most recently updated versions. The facility policy titled, Infection Prevention and Control Program, reviewed/revised 12/27/23 read, in part: .The facility shall conduct an annual review of the infection prevention and control program, including associated programs and policies and procedures .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure accurate and timely delivery of medications for four Residents (R13, R28, R29, and R80) of six residents reviewed for medication administration with 5 errors out of 26 opportunities resulting in a medication error rate of 19%. Findings include:Resident #28 (R28)During a medication administration observation for R28 on 3/18/26 at 1:04 PM. Registered Nurse (RN) B administered oxycodone 5 milligrams (mg) one tab by mouth and methocarbamol 500 mg one tab by mouth by to R28. R28's medication was delivered late and R28 only received one oxycodone and was to receive two tabs. (Error #1) Review of R28's medication administration record (MAR), dated March 2026, unveiled the following order:Oxycodone 5 mg give 2 tablets by mouth every 6 hours for moderate to severe pain with scheduled times at 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM. Resident #80 (R80)On 3/18/26 at 1:30 PM, an observation was made of RN B providing a medication pass for R80 who was administered peg tube feeding 237 milliliters (ml) via peg tube and a water flush of 240 ml. R80 received his tube feeding administration thirty minutes late. RN B was waiting to prepare water for R80 peg tube feed flush for over fifteen minutes before she just went to medication cart and took water from her pitcher with her personal protective gown on. (Error #2) Review of R80's MAR, dated March 2026, unveiled the following order:Enteral Feed Order five times a day Bolus 1 can of Jevity 1.5 (237 ml) 5x's/day via peg tube with scheduled time at 8:00 AM, 12:00 PM, 5:00 PM, 9:00 PM, and 1:00 AM. Resident #13 (R13)On 3/18/26 at 2:03 PM, an observation was made of RN B providing a medication pass for R13 who was administered peg tube feeding 237 ml via peg tube, glycopyrrolate 10 mg and a water flush of 240 ml. R13 received his tube feeding administration over an hour late. R13's micky tubing was noted to be on top of his bedside table lying on a piece of paper towel with a second paper towel over the top of it and not stored in a zip lock bag. (Error #3) Review of R13's MAR, dated March 2026, unveiled the following order:Enteral Feed Order five times a day Bolus 1 can of TwoCal HN 1.5 (237 ml) 5x's/day via peg tube with scheduled time at 7:00 AM, 12:00 PM, 4:00 PM, 8:00 PM, and 4:00 AM. Resident #29 (R29)During a medication administration observation for R29 on 3/18/26 at 3:19 PM. RN B administered enoxaparin 30 mg subcutaneous injection and midodrine 10 mg by mouth to R29. R29's medication was delivered late as the enoxaparin was scheduled for 9:00 AM and the midodrine was scheduled for 1:00 PM. (Error #4 and #5) Review of R29's MAR, dated March 2026, unveiled the following order:Midodrine Oral Tablet 10 mg give 1 tablet by mouth three times a day for pots (sic) with scheduled time at 9:00 AM, 1:00 PM, and 5:00 PM.(brand name) Enoxaparin Solution 30mg/0.3ml inject 30 mg subcutaneously every 12 hours for blood thinner with scheduled time 9:00 AM and 9:00 PM. On 3/18/26 at 3:45 PM, an interview was conducted with RN B who was asked about the late administration of medications and the omission of R28's oxycodone and replied, I only gave him (R28) one. I guess I better double check the order. Oh, gosh. I should have given two. I better go ask him if he wants the second one. RN B proceeded to go ask R28 if he wanted the second oxycodone in which he did. RN B was asked when the last time she work on A-hall was and replied, It has been a couple of weeks. On 3/19/26 at 10:10 AM, an interview was conducted with the Director of Nursing (DON) who was asked what her expectations were of timely and accuracy medication administration and replied, Medications should be given no sooner than an hour before administration time and no longer than an hour after. Nurses should be double checking medications orders for accuracy. Review of policy titled, Medication Administration, dated 1/17/23, read in part Policy: 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. Policy Explanation and Compliance Guidelines.11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time of administration. NOTE - If medication dispensed in a different dose/quantity per dose (example 1/2 pill or give 2 pills) a sticker will be placed on the medication packaging to denote to check the MAR for (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clarification.Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects.Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to label opened multi-use medications, removed expired medications and ensure storage of medications according to professional standards of practice in two of two medication carts reviewed.Finding include:Review of the D-Hall medication cart with Registered Nurse (RN) R on 03/19/2026 at 8:40 AM, revealed the following: A multi-dose Humalog (rapid-acting insulin) U-100 vial stored inside a clear plastic bag. The vial was observed to be without a protective cap, indicating the medication was opened. The vial was noted to belong to Resident #57 and had a written open date of 2/14/2026 and expiration date of 3/14/2026. RN R confirmed the medication was expired and should have been removed from the active medication supply. An open multi-dose Symbicort 80 mcg (microgram)/4.5 mcg inhaler (medication used to treat asthma and chronic obstructive pulmonary disease). Upon inspection of the inhaler and box the inhaler was stored in, it was noted there was no written date of when the inhaler was opened and first used or when the medication would expire. When asked when the medication was opened and when it would expire, RN R confirmed the medication was an active supply and there was no dating on the inhaler or the storage box indicating when the inhaler was first used. RN R reported she was unsure if the medication had a shortened expiration date once opened. A clear plastic bag containing a multi-dose tube of erythromycin (antibiotic) ophthalmic ointment, a multi-dose bottle of moxifloxacin (antibiotic) ophthalmic solution, and a multi-dose bottle of polymyxin B sulfate/trimethoprim (antibiotic) ophthalmic solution. Resident #63's (R63) name was noted to be written on the outside of the clear plastic bag. RN R reported all the medications in the bag were currently prescribed and consistently being administered to R63. Further inspection of each medication with RN R revealed no written open date or expiration date listed on the medications. RN R reported she was unsure how long each medication could be used before expiring. On 3/19/2026 at 9:24 AM RN R reported she checked with the Director of Nursing (DON) regarding R63's ophthalmic medications and was instructed that no open or expiration date was needed to label the multi-dose medications because there's enough preservative in the solution to keep it good. Review of the facility's pharmacy reference guide provided by the DON revealed the following: Humalog Vial . Product expires 28 days after first use or removal from refrigerator, whichever comes first. Symbicort Discard when the counter reads 00 or 90 days after removal from the protective foil package, whichever comes first. It was noted that R63's ophthalmic medications were not listed on the facility's pharmacy reference guide. On 3/19/2026 at 10:15 AM, the DON reported the facility's pharmacy reference guide was not all inclusive. The DON was asked how staff determined what medications had shortened expiration dates (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	upon opening if not included in the pharmacy guide to which she reported staff should refer to the manufacturer's inserts for each respective medication. On 3/19/2026 at 11:08 AM, the DON reported she reviewed the manufacturer's instructions for R63's moxifloxacin and polymyxin B sulfate/trimethoprim ophthalmic solutions and found both medications had shortened expiration periods of 28-30 days after opening. The DON reported she could not find a reference for R63's erythromycin ointment and therefore would defer to the manufacturer's printed expiration date on the medication tube. The DON reported she did not contact the facility consultant pharmacist to inquire about R63's erythromycin ointment. The DON confirmed all multi-dose medications should be labeled with the date the medication was initially opened and with expiration dates when indicated. On 3/18/26 at 2:30 PM, an observation was made of the A-hall medication cart for storage and compliance and was found to have two loose pills in the second draw identified as Baclofen 10 milligrams (mg) with marking IV/4936 and Carvedilol 3.125 mg with marking 1/Z both were white and round in color. The A-hall medication cart had several small pieces of paper and medication particles in the bottom of draw two. On 3/18/26 at 2:40 PM, an interview was conducted with the Nursing Home Administrator (NHA) who was given the medication found loose in medication cart A-hall to dispose of. The NHA remarked we have a small vacuum to clean the medication carts out with. I am not sure why they are so dirty. On 3/19/26 at 10:10 AM, an interview was conducted with the Director of Nursing (DON) who was asked how often the nurses were to clean out the medication carts and replied, Weekly. The DON was asked if the facility had a small vacuum to clean the carts out why were they so dirty and replied, I did not know we had a vacuum to clean the medication carts out. I will have to see about that. Review of policy titled, Medication Administration, dated 1/17/23, read in part Policy: 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. Policy Explanation and Compliance Guidelines: Keep medication cart clean, organized, and stocked with adequate supplies.

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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 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. Based on observation, interview, and record review the facility failed to provide an order, care plan interventions and goals for one Resident (Resident #58) of two residents reviewed for indwelling catheters.Findings include:Resident #58 (R58)On 3/17/26 at 12:50 PM, R58 was observed sitting in his wheelchair in the hallway. A urinary catheter drainage bag, attached to the wheelchair beneath the seat, was touching the floor beneath the wheelchair and dragging on the floor when the wheelchair was propelled. On 3/18/2026 at 8:40 AM, an observation was made of R58 sitting in his wheelchair in the lobby near the A-hall entrance. R58 proceeded to self-propel himself the wheelchair down A-hall with his catheter bag dragging on the floor in a privacy bag. R58's privacy bag had visible dust on the front, sides, and back of the privacy bag. On 3/18/26 at 8:42 AM, an interview was conducted with Certified Nurse Aide (CNA) F who was asked if R58's bag should be dragging on the floor collecting dust. CNA F replied, No, absolutely not. Review of R58's order summary, dated 9/17/26 through 3/18/26 unveiled no physician orders for an indwelling urinary catheter. R58's medical record was reviewed and lacked any order for an indwelling urinary catheter, care plan, interventions, goals, care, or monitoring. On 3/19/2026 at 10:10 AM, an interview was conducted with the DON who was asked what her expectations were for a resident with an indwelling urinary catheter and replied, To have an order indicating the size, care plan interventions, and monitoring. Review of policy titled, Appropriate Use of Indwelling Catheters, dated 12/28/2023, read in part Policy: It is the policy of this facility to ensure that a resident who is continent of bladder on admission receives services and assistance to maintain continence unless his/her clinical condition is or becomes such that continence is not possible to maintain.Policy Explanation and Compliance Guidelines.4. The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of the catheter necessary, size of the catheter, and frequency of changing (if applicable).6. Documentation to support decision making will be included in the medical record, including but not limited to.d. Services provided to restore normal bladder function to the extent possible.8. Indwelling urinary catheters (urethral or suprapubic) will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible.9. The care plan addresses the use of an indwelling urinary catheter, including strategies to prevent complications.

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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 physician orders for the administration of supplemental oxygen, completion of respiratory assessments with respiratory treatments, appropriate cleaning and storage of respiratory equipment, and supervision during the administration of respiratory treatments for three Residents (R36, R80, R13) of five residents reviewed for respiratory care services. Findings include:Resident #80 (R80) On 3/17/26 at 3:05 PM, an observation was made of R80's nebulizer mask (a mask that goes over the nose/mouth/tracheostomy to direct vaporized medication into the airway) stored with tubing and mask connected in a bag with visible condensation in the medication cup. An interview was conducted on 3/17/26 at 3:10 PM, with Unit Manager/Registered Nurse (RN) C who was asked if the nebulizer mask was stored properly and replied, No, it should be taken apart rinsed out and left to dry and then stored in the bag apart. During an observation of R80 on 3/18/26 at 3:00 PM and at 3:20 PM. R80 was lying in bed receiving a nebulizer treatment with a mask and R80 was unattended during the treatment by RN B. On 3/18/26 at 3:30 PM, an interview was conducted with RN B who was asked about the nebulizer treatment procedure and storage and replied, I was unaware that I was required to stay in the room during the administration of the treatment. I did not rinse the nebulizer mask out and I should have. On 3/19/26 at 8:19 AM, an observation was made of R80 in his room lying in bed and receiving a nebulizer treatment with a mask and R80 was unattended by a RN M during the treatment. R80's nebulizer mask was not in the proper place of his tracheostomy (a surgical opening in the windpipe establishing an airway) and the mask was hanging down on his right shoulder. Certified Nurse Aide (CNA) F was present in the room with R80 and adjusted his mask. At 8:55 AM on 3/19/26, an observation was made of R80 in his room lying in bed who continued to receive the same nebulizer treatment with a mask and R80 was unattended by RN M. On 3/19/26 at 9:08 AM, an interview was conducted with RN M who was asked to walk this Surveyor through the process of delivering a nebulizer treatment to residents. RN M properly gave the steps on how to administer a nebulizer treatment. RN M admitted she failed to supervise the resident and rinse and store the equipment post treatment. Resident #13 (R13) On 3/17/26 at 3:05 PM, an observation was made of R13's nebulizer mask (a mask that goes over the nose/mouth/tracheostomy to direct vaporized medication into the airway) stored with tubing and mask connected in a bag with visible condensation in the medication cup. An interview was conducted on 3/17/26 at 3:10 PM, with Unit Manager/RN C who was asked if the nebulizer mask was stored properly and replied, No, it should be taken apart rinsed out and left to dry and then stored in the bag apart. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/26 at 8:19 AM, an observation was made of R13 in his room lying in bed and receiving a nebulizer treatment with a mask and R13 unattended by a RN M. R13's nebulizer mask became unattached from his tracheostomy. CNA F was present in the room with R13 and reattached the nebulizer mask to his tracheostomy. At 8:55 AM on 3/19/26, an observation was made of R13 in his room lying in bed who continued to receive the same nebulizer treatment with a mask and R13 was unattended by RN M. On 3/19/2026 at 10:10 AM, an interview was conducted with the Director of Nursing (DON) who was asked what her expectations were for a residents receiving nebulizer treatment and replied, To have pre and post assessment, for nursing to remain in the resident room until the treatment is completed and to rinse and let the respiratory equipment dry properly. Review of policy titled, Nebulizer Therapy, dated 5/15/24, read in part Policy: It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions. Policy Explanation and Compliance Guidelines: 1. Care of the Resident.n. Observe resident during the procedure for any changes in condition. o. When medication delivery is complete, turn the machine off. Treatment may be considered complete with the onset of nebulizer sputtering. p. Disassemble and rinse the nebulizer water and allow to air dry. 2. Care of the Equipment. a. Clean after each use.c. Disassemble parts after every treatment. d. Rinse the nebulizer cup and mouthpiece with water. e. shake off excess water. f. Air dry on an absorbent towel. g. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. Resident #36 (R36) On 3/17/26 at 1:17 PM, R36 was observed lying in bed with a nasal cannula (flexible tubing that delivers supplemental oxygen into the nostrils) below her chin. R36 appeared agitated, moving her head side to side and continuously moving her extremities. An elastic band encircled R36's head in the forehead region. On 3/17/26 at 1:20 PM, Licensed Practical Nurse (LPN) J was queried regarding the oxygen requirements of R36 and the purpose of the elastic band on the head of R36. LPN J said R36 required the continuous use of supplemental oxygen but kept removing the nasal cannula. LPN J said the elastic band was intended to keep the nasal cannula in place. Review of the electronic medical record (EMR) disclosed R36 was hospitalized on [DATE] with acute respiratory failure with hypoxia (low levels of oxygen in body tissues) and pneumonia. R36 returned to the facility on 2/11/26. Further review of the EMR for 36 revealed a care plan dated as initiated 2/20/26 that read: Resident has an impaired pulmonary/respiratory status related to respiratory failure w/ [with] hypoxia. An intervention dated 2/20/26 read: Oxygen as ordered. The EMR of R36 did not contain a physician's order for supplemental oxygen. On 3/19/26 at 8:04 AM, R36 was observed lying in bed with the nasal cannula in only one nostril. R36 had audible crackles with inspiration and was coughing intermittently. The EMR of R36 included a physician's order for albuterol sulfate (a medication used to relax airway (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	muscles and improve airflow in the lungs) by a nebulizer (an aerosol system that allows medication to be inhaled directly into the lungs) three times per day. LPN J was observed administering an albuterol sulfate nebulizer treatment for R36 on 3/19/26 at 8:04 AM. LPN J did not conduct a respiratory assessment before or after administering the nebulizer treatment. The Medication Administration Record (MAR), Treatment Administration Record (TAR) and Respiratory Administration Record (RAR) were reviewed on 3/19/26. Respiratory assessments were not documented before or after the three daily administrations of albuterol sulfate through the nebulizer in the month of March 2026. The Vitals portion of the EMR documented R36 had peripheral oxygen saturation (SPO2) levels obtained three times in the month of March 2026. The Director of Nursing (DON) was interviewed on 3/19/26 at 10:51 AM. When asked the frequency of supplemental oxygen for R36, the DON responded that R36 was to have continuous supplemental oxygen delivery. The DON confirmed that a physician's order was required to administer supplemental oxygen to a resident, and the order was to include the flow rate, delivery system, and parameters in which to administer supplemental oxygen. The DON reviewed the physician's orders for R36 and confirmed there was no physician's order for R36 to utilize supplemental oxygen. The DON said supplemental oxygen was usually used between 2-4 liters per minute (lpm) to keep SPO2 levels between 90-95%. When asked the expectation of the frequency of obtaining SPO2, the DON said SPO2 should be obtained at least once per day and as needed for respiratory distress. The DON was queried regarding the expectation for respiratory assessments with medication administration via nebulizer. The DON said respiratory assessments should be completed with each nebulizer treatment, including SPO2. The DON reviewed the EMR of R36 and confirmed respiratory assessments and SPO2 were not completed as expected. The policy Oxygen Administration dated as implement 6/23/25 read, in part: .Oxygen is administered under orders of a physician, except in the case of an emergency.The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system b. When to administer, such as continuous or intermittent and/or when to discontinue c. Equipment setting for the prescribed flow rates d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered e. Monitoring for complications associated with the use of oxygen. The policy Nebulizer Therapy dated as revised 5/15/24 read, in part: .Documentation. d. Resident vital signs and respiratory assessment e. Resident's response to treatment.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to explain and obtain an acknowledgement of understanding for a binding arbitration agreement for one Resident (R10) of three Residents reviewed for proper execution of the facility's binding arbitration agreement.Findings include:After receiving a list of those residents who had signed the facility arbitration contract titled, ALTERNATIVE DISPUTE RESOLUTION AGREEMENT, three residents were interviewed regarding the arbitration agreement process.On 3/18/2026 at 1:05 PM, R10 was interviewed in his room. R10 stated he remembered nothing regarding an arbitration agreement.The electronic medical record revealed R10 was admitted on [DATE] as his own responsible party. The Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15 indicating R10 was cognitively intact.The ALTERNATIVE DISPUTE RESOLUTION AGREEMENT for R10 was reviewed and the final page had been E-signed (electronically signed) on 6/30/25. Twelve of the twenty points in the contract required an initial. Only one of the twelve blanks had been initialed. Point number 19 read, YOU ACKNOWLEDGE AND AGREE: (I) THAT YOU HAVE FULLY READ, UNDERSTAND AND ARE VOLUNTARILY ENTERING INTO THIS AGREEMENT; AND (II) THAT, YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS BEFORE SIGNING THIS AGREEMENT. This point had not been initialed by R10.During an interview on 3/18/2026 at 2:04 PM, the acting admission Director (Staff) U stated, I was not here for this paperwork (R10's arbitration agreement). Staff U indicated she was presently orienting a new Admissions Coordinator.During an interview on 3/18/2026 at 2:15 PM, the Nursing Home Administrator (NHA) and the Business Office Manager (Staff) O reviewed R10's ALTERNATIVE DISPUTE RESOLUTION AGREEMENT and agreed the contract was not completed in full. The NHA said there were areas of improvement for those filling out the agreement in the future.On 3/18/2026 at 2:20 PM, R10 was approached again to discuss the binding arbitration agreement paperwork and the fact that it was not completely signed. R10 responded I probably did not understand it and so I did not sign it.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure communication/documentation occurred for coordination of care for hospice services provided for one Resident (R47) of one Resident reviewed for hospice services.Findings include:A review of the medical record for R47 revealed an admission to the facility with hospice services dated [DATE]. The Minimum Data Set (MDS) assessment dated [DATE] indicated R47 was receiving hospice services. The Resident Roster printed on [DATE] indicated R47 was on hospice. The care plan printed on [DATE] for R47 included a focus of Hospice - Resident has a terminal prognosis with (Name of Hospice) related to end of life diagnosis . Date Initiated: [DATE]During an interview on [DATE] at 3:51 PM, the Registered Nurse (RN) L caring for R47 stated, I have no idea how hospice communicates with the facility. RN L said there were no charting or hospice folders that they were aware of. RN L stated, I get report when they (hospice personnel) have been here. That is all.During an interview on [DATE] at 4:11 PM, the Director of Nursing (DON) showed me the hospice binders containing hospice paperwork and stated, There are 4 or 5 hospices that come here. The hospice binder with records for R47 was reviewed and only contained one care plan. The DON could not find documentation from hospice personnel visits. There was no record of visits, progress, care performed, or future planned visits. Signature sheets were present in the binders, but no resident names were listed to determine who had been visited. The DON remarked the only signature sheet present in the binder with a resident's name recorded on it had died. The DON said she would look further for hospice documentation.During an interview on [DATE] at 4:39 PM, the DON described the hospice procedure but could not find documentation of hospice visits for R47. The DON had reviewed the medical record for R47 but could not determine the hospice service frequency, when hospice personnel (nurses, aides, social workers or chaplains) were here last, what services had been provided, or when the next planned visits were scheduled. The DON stated the hospice RN did often touch base but there was no documentation.During an interview on [DATE] at 4:50 PM, the Nursing Home Administrator (NHA) stated the hospice documentation might not yet be scanned into the medical record. She went to the medical records office but could not find documentation. The NHA agreed hospice collaboration was missing. During an interview on [DATE] at 10:02 AM, the DON said, some of the hospices did talk to her and filled out logs but others did not and no further hospice documentation was provided.The facility provided a policy titled Hospice dated as reviewed/revised [DATE] which read in part, .1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the residents' care. 4. The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility. 6. The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure eligible residents were offered influenza and pneumococcal vaccines as recommended by the Centers for Disease Control and Prevention (CDC) for 2 residents (#12 and #87) of 5 residents reviewed for vaccination status.Findings Include:Resident #12 (R12)Review of R12's Electronic Medical Record (EMR) revealed initial admission to the facility on 1/22/26 with diagnoses including cerebral infarction (stroke), moderate persistent asthma, dementia, and dysphagia (difficulty swallowing).Review of R12's Michigan Care Improvement Registry (MCIR [a database that documents immunizations administered to individuals in Michigan]) revealed the pneumococcal vaccination was, DUE NOW.Further review of R12's EMR revealed she was not offered a pneumococcal immunization.Resident #87 (R87)Review of R87's EMR revealed initial admission to the facility on 7/19/22 with diagnoses including congestive heart failure (CHF), vascular dementia, and peripheral vascular disease.Review of R87's MCIR revealed the following, Immunization Status and Shots Needed: Vaccine: PCV15 (Pneumococcal 15-valent conjugate vaccine)/PCV20/PCV21. Next Dose Due: Overdue. Overdue Date: 10/28/2020. Vaccine: Seasonal Influenza. Next Dose Due: Overdue. Overdue Date: 10/1/25.Further review of R87's EMR revealed he was not offered a pneumococcal or influenza immunization.On 3/19/26 at 11:15 AM, an interview was conducted with Infection Preventionist (IP) N who verified responsibility for the Infection Prevention and Control Program (IPCP) including the vaccination program. IP N verified R12 and R87 had not yet been offered their eligible immunizations per facility policy but was working to get caught up.Review of the facility policy titled, Pneumococcal Vaccine (Series), reviewed/revised 10/20/23, read, in part: It is our policy to offer our residents, staff, and volunteer workers immunizations against pneumococcal disease in accordance with current CDC guidelines and recommendations. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated.Review of the facility policy titled, Influenza Vaccination, reviewed/revised 10/26/23, read, in part: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunizations against influenza. Influenza vaccinations will be routinely offered from October 1st through March 31st unless such immunization is medically contraindicated.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure eligible residents were offered a COVID-19 immunization as recommended by the Centers for Disease Control and Prevention (CDC) for 2 residents (#12 and #87) of 5 residents reviewed for vaccination status.Findings Include:Resident #12 (R12)Review of R12's Electronic Medical Record (EMR) revealed initial admission to the facility on 1/22/26 with diagnoses including cerebral infarction (stroke), moderate persistent asthma, dementia, and dysphagia (difficulty swallowing).Review of R12's Michigan Care Improvement Registry (MCIR [a database that documents immunizations administered to individuals in Michigan]) revealed COVID-19 2025-26 was, DUE NOW.Further review of R12's EMR revealed she was not offered a COVID-19 immunization.Resident #87 (R87)Review of R87's EMR revealed initial admission to the facility on 7/19/22 with diagnoses including congestive heart failure (CHF), vascular dementia, and peripheral vascular disease.Review of R87's MCIR revealed the following, Immunization Status and Shots Needed: Vaccine: COVID-19 2025-26. Next Dose Due: Overdue. Overdue Date: 8/27/2025.Further review of R87's EMR revealed he was not offered a COVID-19 immunization.On 3/19/26 at 11:15 AM, an interview was conducted with Infection Preventionist (IP) N who verified responsibility for the Infection Prevention and Control Program (IPCP) including the vaccination program. IP N verified R12 and R87 had not yet been offered their eligible immunizations per facility policy but was working to get caught up.Review of the facility policy titled, COVID-19 Vaccination, reviewed/revised 12/31/25, read, in part: It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine. COVID-19 vaccinations will be offered to residents when supplies are available, as per CDC and/or FDA [Food and Drug Administration] guidelines unless such immunizations is medically contraindicated.