STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235354	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Health and Rehabilitation	55378 Wilbur Rd Three Rivers, MI 49093

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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 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 call lights were within reach for 1 of 2 residents (R102) reviewed for accommodation of needs, resulting in the potential for residents to not meet their highest practicable level of well-being.Findings include:According to R102's Minimum Data Set (MDS), dated [DATE], indicated the resident was severely cognitively impaired and required assistance with most activities of daily living (ADLs).Observations:-10/20/25 at 3:15 PM a round soft-touch call light was under the sheet to the left side of R102's bed approximately waist level to the resident.- 10/21/25 at 8:12 AM, R102 eyes closed in bed. Soft touch call light clipped to fitted sheet at head of bed, out of sight and reach of resident.-10/21/25 at 10:05 AM, R102 eyes closed in bed. Soft touch call light clipped to fitted sheet at head of bed, out of sight and reach of resident.-10/21/25 at 3:20 PM, R102 was lying in the fetal position on his left side in bed. Call light positioned underneath fitted bed sheet parallel to resident's waist which was out of sight and reach of resident. During an interview on 10/24/25 with Unit Manager (UM) E stated, The call light should be accessible for (R102). I know why staff put it under his sheet, so if he got out of bed he would roll on the call light and maybe set it off. Staff should not have done that.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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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 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number: 2640123Based on observation, interview, and record review, the facility failed to prevent the use of psychotropic medications without adequate indication for use and without resident monitoring in one (R102) of two residents reviewed for psychotropic medications, resulting in an immediate jeopardy when beginning on 9/16/25, R102 was prescribed psychotropic medications, who then experienced increased sedation, weight loss, and decreased ability to communicate. Findings include:Resident #102 (R102) was prescribed Haldol solution injection intramuscular (IM) daily as needed PRN and Olanzapine (Zyprexa) 5mg by mouth (PO) daily at night beginning 9/16/25. The Olanzapine was increased to 10 mg PO daily at night on 10/20/25. R102 experienced falls, some with injuries, beginning 9/16/25 after having no falls since 9/11/25 admission. Resident #102 did not have a psychiatric diagnosis to indicate the need for two psychotropic medications. On 10/22/25, R102 was observed with increased lethargy, inability to eat or drink, weight loss, and altered mental status. The resident was transferred to a neuro psychiatric hospital on [DATE], where he was evaluated upon admission to be medically unstable and transferred to an acute hospital where he weighed 101pounds and was dehydrated. The Immediate Jeopardy (IJ) began on 9/16/25 when R102 was prescribed psychotropic medications without adequate indication for use and without resident monitoring, who then experienced increased sedation, weight loss, and decreased ability to communicate.Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on 10/23/25 at 2:30 PM. The surveyor confirmed by interview and record review the Immediate Jeopardy was removed on 10/27/25, but noncompliance remains at actual harm due to not all staff having received education and sustained compliance had not been verified by the State Agency. Review of R102's Minimum Data Set (MDS) dated [DATE], revealed the resident had been admitted on [DATE] with a severe cognitive impairment indicated by a BIMS (Brief Interview Mental Status) score of 3/15 and the ability to feed himself. Diagnoses included other sequelae of cerebral infarction (resulting conditions after a stroke has occurred), dementia unspecified severity with other behavioral disturbance (a group of systems that affect memory, thinking, and social abilities to interfere with daily life), vascular dementia severe with other behavioral disturbance (vascular major cognitive impairment), and adjustment disorder with mixed disturbance of emotions and conduct. It was noted there were no psychiatric diagnoses. Review of R102's Progress Notes regarding the resident's behavior and cognition, a Social [NAME] admission History note, dated 9/12/25 10:50 AM, indicated R102 and representative were present along with IDT (interdisciplinary team) members. The note indicated a cognitive summary was reviewed which included mental status changes and evaluation of behaviors if present. No verbal or physical behaviors were documented. The note identified R102 was unaware of where he was and what was going on. Review of R102's Care Plan did not reveal a focus/goal/intervention for a mental health diagnosis (es) nor did it reveal PASARR documentation for a mental health diagnosis(es) that would indicate antipsychotic medications were needed. Further review of R102's Care Plan did reveal a focus stating the resident uses psychotropic medications (antipsychotic) related to behavior management dated 9/22/25. The goal was to remain free of psychotropic drug related complications using interventions including administering the psychotropic medications and monitoring for side effects. The care plan's treatment did not indicate a mental health diagnosis(es) nor name the antipsychotic medications. Interventions stated the ongoing need for the use of psychotropic medications would be discussed with the Medical Director and the family. Regarding the incident on 9/16/25, R101's Guardian EE stated during an interview on 10/23/25 at 8:26 AM, I told staff he was picked on by a group of younger women from the facility he was at before here. If they left him alone, he never had any problems. I told staff that the name [NAME] is a trigger for him and asked staff if they could not say that name loudly or near (R102). [NAME] was (R102's) ex-wife's name and she was mean and abusive to him. I don't think the staff at this facility listens to me when I tell them what sets (R102) off. I also told staff at admission (R102) like Pepsi, chocolate, coffee, and to go for walks. I don't think staff did those suggestions before he got the Haldol shots. Review of R102's Care Plan, dated 9/15/25, focus of Activities of Daily Living (ADL) indicated the resident goal was to maintain functional ability and was able to feed himself. Review of R102's Care Plan, dated 9/22/25, focus of Potential Fluid Deficit, goal was to be free of symptoms of dehydration and maintain moist mucous membranes, and good skin turgor. Interventions to meet this goal included encouraging the resident to drink fluids of choice and to ensure access to fluids whenever possible. Also

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide resident centered activities designed to support leisure needs for 1 (Resident #102) of 3 residents reviewed for activities, resulting in the potential for decreased physical, mental, and psychosocial well-being.Findings include:Review of The Needs of Older People with Dementia in Residential Care, [NAME] G. A. Woods B. [NAME] D., & [NAME] M. (2006). Published by in the International Journal of Geriatric Psychiatry, 21, 43-49. doi:10.1002/gps.1421 revealed Determining which activities have high degrees of meaningfulness can aide recreation staff in creating programs more likely to promote health and wellness for persons with dementia.Resident #102Review of an admission Record revealed Resident # 102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia with other behavioral disturbance(a type of brain disorder that causes cognitive decline due to damage to the blood vessels in the brain), adjustment disorder with mixed disturbance of emotions and conduct(maladaptive response to psychological stressor), and other sequalae of cerebral infarction (long term complications of a stroke).Review of a Minimum Data Set (MDS) assessment for Resident #102 with a reference date of 9/17/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3/15, which indicated the resident was severely cognitively impaired. Section B revealed Resident #102 had unclear speech, was only sometimes able to understand or make self-understood and had highly impaired vision. Further review revealed Resident #102 displayed inattention, hallucinations (perceptual experiences in the absence of reality), delusions (misconceptions or beliefs contrary to reality), and behaviors that significantly interfered with the ability to participation in activities or social interactions. Section GG revealed Resident #102 was dependent (helper does more than 75% of the effort) for propelling his wheelchair 50' and his ability to walk was not assessed due to safety concerns/medical condition.Review of a Care Plan for Resident #102 with a reference date of 9/17/25 revealed the following focuses/goal/interventions: Focus #1.When (inaccurate nickname of Resident #102) displays aggression, a calm walk and conversation to de-escalate, offer the sensory room, use the sensory objects available to calm.will continue to support his social needs as he tolerates. Focus #2 (added 10/15/25) Add to sensory group three days per week Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired.Interventions: Introduce the resident to residents with similar background, interests and encourage interaction, Invite the resident to scheduled activities.POA (Power of Attorney) suggests following ideas for redirection: chocolate, outside activities, Pepsi, coffee, fidget blankets, Pop IT (sensory tool with rubber bubbles that pop), country music, western shows, use sensory room or low lighting for low stim if resident is escalating. Review of an Activity Initial Review for Resident #102 with a reference date of 9/16/25 revealed: PAST ACTIVITY INTERESTS: Family, reading, tv, movies, SPIRITUAL: Christian.Does the resident wish visits by clergy of choice: No. LIMITATIONS/SPECIAL NEEDS: 1. Activities should be modified to accommodate cognitive deficit.No, 2. Activities should be modified to address communication deficit.No,.4. Activities should be modified to address visual deficit.No.5. Assistance should be provided to get resident to the activity.No.Review of an Activity Attendance Log for Resident #102 with reference date range of 9/11-10/26/25 revealed Resident #102 attended Sensory Stimulation once during the 6-week period. 9 instances of Resident #102 actively pursuing religious study independently are documented along with at least 24 instances in which Resident #102 was documented as actively pursuing jigsaw puzzles independently during the same period.In an interview on 10/30/25 at 8:21am, Durable Power of Attorney (DPOA) EE reported staff from the facility never asked her about Resident #102's past leisure interests and he would not have been able to accurately express his interests. DPOA EE reported Resident #102 could not participate in traditional leisure activities due to his cognitive deficits. When queried, DPOA EE reported Resident #102 could not work on jigsaw puzzles, read to himself, or watch television due to cognitive and visual deficits. When informed Resident #102 was documented as attending religious services, DPOA EE reported religion was never important to Resident #102 and he never went to church a day in his life. When further queried, DPOA EE reported she visited Resident #102 at the facility several times a week and never saw him participating in any activities.In an interview on 10/30/25 at 1:13pm, Registered Nurse (RN) N reported she cared for Resident #102 several times per week, and the resident almost never participated in any type of activity and needed 1:1(constant support of one staff member) assistance to pursue any kind of leisure interests. RN N reported activities were important to residents with dementia because involvement

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview, and record review, the facility failed to complete annual performance reviews for 3 Certified Nursing Assistants (CNAs) (CNA's T, X, and KK) of 3 reviewed for regular performance evaluations, resulting in the potential for unidentified CNA performance concerns, a lack of training related to staff performance review outcomes, and the potential for unmet care needs.Findings include:In an email sent to Nursing Home Administrator (NHA) A on 10/30/25 at 8:12am, annual performance reviews were requested for CNA's T, X and KK.Review of personnel files for CNA's T, X, and KK revealed no annual reviews were present for the past 12 months. Further review of the employee files revealed all CNA's had been employed by the facility for more than 12 months.In an interview on 10/30/25 at 12:51pm, Business Office Manager (BOM) BB reported every nursing assistant should have a performance review done at least every 12 months and the evaluation should be kept in the employee file. BOM BB reviewed the employee files for CNA T, X and KK and confirmed no performance reviews completed in the last 12 months were present.In an interview on 10/30/25 at 1:27pm, BOM BB reported she spoke with NHA A regarding the lack of performance evaluations in the CNA employee files. BOM BB stated I heard it from the horse's mouth; performance evaluations were not done. BOM BB confirmed that performance reviews were important to ensure staff had the skills needed to complete their job duties.In an interview on 10/30/25 at 3:16pm, NHA A reported he was aware the CNA performance reviews had not been completed in the last 12 months. NHA A confirmed performance reviews were necessary in order to ensure staff have the necessary skills to care for residents.Review of a facility policy titled Nurse Aide Training Program with a reference date of 10/28/25 revealed: .5. Additional training will be provided to each nurse aide based on any areas of weakness as determined in the nurse aide's performance reviews.education that is needed based on the performance appraisal will be completed within 90 days of the appraisal. Review of The Essentials Guide to Healthcare Performance Reviews, www.hrforhealth.com , 2024, revealed The benefits of healthcare performance reviews go beyond creating a better experience for your team.the most important (benefit) is performance reviews lead to improved performance.greater productivity and better overall experience for your patients.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number: 2640123Based on observation, interview, and record review the facility failed to develop and implement person centered dementia care interventions to address wandering, disorientation, and frustration for 1 (Resident #102) of 3 residents reviewed for dementia care, resulting in Resident #102 experiencing ongoing wandering, emotional frustration, and stress.Findings include:Review of The Unmet Needs Model, [NAME]-[NAME] and [NAME] (1995), revealed that those with dementia develop problem behaviors from an imbalance in the interaction between life-long habits and personality, current physical and mental states and less than optimal environmental conditions. Resident #102 Review of an admission Record revealed Resident #102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia with other behavioral disturbance (a type of brain disorder that causes cognitive decline due to damage to the blood vessels in the brain). Review of a Minimum Data Set (MDS) assessment for Resident #102 with a reference date of 9/17/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3/15, which indicated the resident was severely cognitively impaired. Section B revealed Resident #102 had unclear speech, was only sometimes able to understand or make self-understood and had highly impaired vision. Further review revealed Resident #102 displayed inattention, hallucinations (perceptual experiences in the absence of reality), delusions (misconceptions or beliefs contrary to reality), and behaviors that significantly interfere with the ability to participation in activities or social interactions. Review of a Care Plan for Resident #102 with a reference date of 9/17/25 revealed the following focuses/goals/interventions: Focus #1.When (inaccurate nickname of Resident #102) displays aggression, a calm walk and conversation to de-escalate, offer the sensory room, use the sensory objects available to calm. will continue to support his social needs as he tolerates. Focus #2 (added 10/15/25) Add to sensory group three days per week Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired.Interventions: Introduce the resident to residents with similar background, interests and encourage interaction, Invite the resident to scheduled activities.POA (Power of Attorney) suggests following ideas for redirection: chocolate, outside activities, Pepsi, coffee, fidget blankets, Pop IT (sensory tool with rubber bubbles that pop), country music, western shows, use sensory room or low lighting for low stim if resident is escalating.Focus #3(initiated on 9/12/25): The resident has a behavior problem related to dementia with behaviors, Goal: The resident will have fewer episodes of behaviors.Interventions: Administer medications as ordered, Anticipate and meet the resident's needs.stop and talk to him as passing by. Review of a Physician Order for Resident #102, with a reference date of 10/22/25 (40 days after the resident's admission) revealed Non-pharmacological Interventions attempted prior to medication administration, every shift using the following codes to document the intervention(s) used: 1=Repositioning, 2=Dim light, 3=Hot/cold applications, 4=Relaxation techniques, 5=Distraction, 6=Music, 7=Massage. The interventions suggested by Resident #102's DPOA were not included. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Activity Attendance Log for Resident #102 with reference date range of 9/11-10/26/25 revealed Resident #102 attended Sensory Stimulation once during the 6-week period. In an interview on 10/30/25 at 8:21am, activated Durable Power of Attorney (DPOA) EE reported no one at the facility asked her about interventions that alleviated Resident #102's stress responses. DPOA EE she noticed Resident #102 appeared increasingly stressed in the days following his admission, at which time she told staff members about interventions that help reduce Resident #102's agitation. DPOA EE reported she never saw staff members implement the interventions. DPOA EE reported Resident #102 had a history of trauma that included a physically and emotionally abusive spouse, and caregiver neglect prior to her becoming his DPOA. When queried about Resident #102's preferred name, DPOA EE confirmed the nickname in Resident #102's care plan was incorrect. Review of a Trauma Screen for Resident #102 with a reference date of 9/12/25 revealed Life Event Questions: 6. Physical assault.Doesn't apply.13. Severe human suffering.Doesn't apply.a2. Interviewee: a. Resident. In an interview on 10/27/25 at 12:57pm, Licensed Practical Nurse (LPN) U reported she cared for Resident #102 regularly. LPN U described Resident #102 as hard to handle, and that he could be very mean and scary. LPN U reported she was not sure what triggered Resident #102 when he became upset. When queried, LPN U denied receiving any dementia care training from the facility. LPN U reported she had learned from caring for him that Resident #102 liked to nap after breakfast and appeared to happier when able to do so. This preference was not noted in Resident #102's care plan. In an interview on 10/30/25 at 1:13pm, Registered Nurse (RN) N reported she regularly cared for Resident #102 and although he was restless and agitated at times, she was able to apply dementia care techniques that reduced his stress responses. RN N reported she had a good relationship with Resident #102. RN N reported she observed some staff members had a lack of understanding of dementia, struggled to redirect Resident #102 and needed to have more patience when caring for him. RN N reported she felt the facility needed to provide additional dementia care training so staff would have the skills necessary to support each resident in attaining their best quality of life. Review of an Activity Initial Review for Resident #102 with a reference date of 9/16/25 revealed: PAST ACTIVITY INTERESTS: Family, reading, tv, movies, SPIRITUAL: Christian.Does the resident wish visits by clergy of choice: No. LIMITATIONS/SPECIAL NEEDS: 1. Activities should be modified to accommodate cognitive deficit.No, 2. Activities should be modified to address communication deficit.No,.4. Activities should be modified to address visual deficit.No.5. Assistance should be provided to get resident to the activity.No. In an interview on 10/30/25 at 2:08pm, Activity Assistant (AA) DD reported she was the primary activity staff member for Resident #102's unit. AA DD reported Resident #102 could not answer questions about his leisure preferences and she was not told what he liked. When queried about Resident #102's psychosocial well-being, AA DD reported Resident #102 seemed like he was suffering with a lot of emotional pain but would calm down when offered gentle back rubs and reassurance. AA DD reported Resident #102 was very protective of his hands and was triggered if his hands were not handled gently. Back rubs and gentle handling of Resident #102's hands were not listed as interventions in Resident #102's care plan. AA DD reported she was aware of at least one staff member on the memory care unit who did not know how to effectively reduce Resident #102's stress responses. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/30/25 at 3:16pm, Nursing Home Administrator (NHA) A reported he felt the facility needed to implement a performance improvement plan to address the quality of Dementia Care provided at the facility. Review of a Dementia Care policy with a reference date of 1/3/25 revealed Policy: It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. Policy explanation.:The facility will assess, develop, and implement care plans through an interdisciplinary team approach that includes the resident, their family.Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities.Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity.autonomy.choice.All staff will be trained on dementia and dementia care practices upon hire, annually, and as needed. Observed -10/21/25 at 8:12 AM, R102 eyes closed in bed. Soft touch call light clipped to fitted sheet at head of bed, out of sight and reach of resident. Resident was lying on his left side with both legs over the edge of the bed with feet touching the floor. No radio, books, or magazines available for the resident in room. -10/21/25 at 10:05 AM, R102 eyes closed in bed, hands fidgeting with bed sheet. Resident was lying on his left side with both legs over the edge of the bed with feet touching the floor. No radio, books, or magazines available for the resident in room. -10/21/25 at 3:20 PM, R102 was lying in the fetal position on his left side in bed with eyes closed. No radio, books, or magazines available for the resident in room. Interviews -10/21/25 at 4:00 PM, Activities Director LL stated, There are three men on the locked dementia unit with no planned activities for men. There are no activities planned for the locked dementia unit after 3 PM for any residents. I understand the concerns with dementia activities on the locked unit, and I have the same ones. -10/21/25 at 3:10 PM Certified Nursing Assistant (CNA) R stated, There are no activity aides after 3 PM on this unit, locked. It is hard for 2 CNAs and 1 nurse to care for dementia residents, especially in the evenings. After dinner, the CNAs must clean up trays, clean up and toilet residents, then it's time to get residents ready for bed. The nurse is doing medications and treatments. Some of the residents are two-person assist so then there is only the nurse, maybe in the hall or maybe in a resident room. Dementia residents get restless, especially in the evening hours. There is no organized activity for them on this unit. The way this unit is staffed, there is no good way to care for dementia residents, especially after dinner. -10/22/25 at 8:36 AM, Guardian EE stated, I was told (R102) went to the hospital last week because he was uncontrollable. I have told staff when he first came there when he is asleep, he doesn't like to be woken up. When they check his brief at night it makes him upset. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/22/25 at 3 PM, CNA T stated, (R102) does a lot of swinging when changing and undressing him. Yesterday, (10/21/25) another CNA and I were providing (R102) cares, change him, clean him up, make him comfortable. He was not with it. His eyes were closed. He did not admit that a month ago. He is not the only resident like that. There are residents that strike out. I just talk to him. It's all about how you approach him. He does not comprehend anything. Residents with dementia need extra attention and patience. They need activities they are interested in, and you can't expect them to sit still very often. (R102) just needs patience. He also likes to go for walks outside and around the unit. This locked unit is too small to really go for walks on and there is not enough staff to meet the needs of dementia resident. -10/23/25 8:26 AM Guardian EE stated, I have not seen (R102) in a couple of weeks because of my schedule. When I was at the facility the last time, he was awake, talking to me, and was good. His ex-wife's name was [NAME]. I know there is a resident on the same unit named [NAME]. When I am visiting him and he hears the name [NAME] he becomes upset. His ex-wife was very mean and abusive to him. I told staff that the name [NAME] is a trigger for him and asked staff if they could not say that name loudly or near (R102). At the facility he came from, there was a group of younger female residents that were mean to (R102). They would pick on him and he would get mad. If they left him alone, he never had any problems. I don't think the staff at this facility listens to me when I tell them what triggers (R102). -10/23/25 at 1:07 PM, Guardian EE stated, I told the staff it would take (R102) a couple of weeks to adjust to their facility. The other facility was bright, and he could go around in his wheelchair. He kept telling me it was too dark in this facility's unit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number: 2640123Based on observation, interview, and record review, the facility failed to maintain a complete and accurate medical record in 1 of 3 residents (Resident #102) reviewed for comprehensive/accurate medical records, resulting in inaccurate documentation and the potential for unmet needs.Findings include:Resident #102Review of an admission Record revealed Resident # 102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia with other behavioral disturbance(a type of brain disorder that causes cognitive decline due to damage to the blood vessels in the brain), adjustment disorder with mixed disturbance of emotions and conduct(maladaptive response to psychological stressor), and other sequalae of cerebral infarction (long term complications of a stroke).Review of a Minimum Data Set (MDS) assessment for Resident #102 with a reference date of 9/17/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3/15, which indicated the resident was severely cognitively impaired. Further review revealed Resident #102 displayed inattention, hallucinations (perceptual experiences in the absence of reality), delusions (misconceptions or beliefs contrary to reality), and behaviors that significantly interfere with the ability to participation in activities or social interactions.Review of a Care Plan for Resident #102 with a reference date of 9/17/25 revealed the following focus/goal/interventions: Focus #1.When (inaccurate nickname of Resident #102) displays aggression, a calm walk and conversation to de-escalate, offer the sensory room, use the sensory objects available to calm.will continue to support his social needs as he tolerates.In an interview on 10/30/25 at 8:21am, Durable Power of Attorney (DPOA) EE reported Resident #102 could not participate in traditional leisure activities due to his cognitive deficits. DPOA EE reported she visited Resident #102 at the facility several times a week and never saw him participating in any activities. DPOA EE reported Resident #102 never went by the nickname listed in his care plan and addressing him by that name would only confuse him. DPOA EE reported she had no knowledge of Resident #102 participating in any kind of outing while at the facility and doing so would have required her permission.In an interview on 10/30/25 at 2:08pm, Activity Assistant (AA) DD reported Resident #102 could not participate in group activities.In an interview on 10/30/25 at 1:13pm, Registered Nurse (RN) N reported she cared for Resident #102 several times per week, and the resident almost never participated in any type of group activity.Review of an Activity Attendance Record for Resident #102 revealed the resident was documented as having attended bingo, movies, a party, a word game group, religious activities, roll and stroll, and outings. The Activity Attendance Record reflected that Resident #102 participated in a group discussion, worked a jigsaw puzzle and was active in a 1:1 (activity in which the resident had a staff member assigned only to him) on 10/26/25.Review of a Nursing Note with a reference date of 10/24/25 at 3:26pm revealed Resident #102 was discharged to an acute care setting at this time and did not return to the facility.In an interview on 10/30/25 at 2:34pm, Activity Director (AD) CC reported she expected activity staff to document residents self-propelling their wheelchairs or looking out the window as self-guided leisure activities. When further queried, AD CC confirmed the act of moving oneself or looking out a window did not meet the definition of a leisure activity. AD CC reported the facility did not offer community outings, but Resident #102 was documented as attending 2 outings. AD CC confirmed Resident #102 was discharged on 10/24/25 but his activity record reflected he actively participated in several activities on 10/26/25. AD CC reported AA DD had difficulty accurately documenting activity attendance for residents and likely entered the information in error.According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing.High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized . Accessed from: Kindle Locations 24106-24108). Elsevier Health Sciences. Kindle Edition.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to ensure the quality assurance and performance improvement (QAPI) program identified and corrected quality deficiencies, resulting in decreased quality of care.Findings include:Review of a Quality Assurance and Performance Improvement(QAPI) policy with a reference date of 6/2025 revealed Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides.Policy Explanation and Compliance Guidelines: The QAPI program includes.a written QAPI Plan. The QAA (Quality Assessment and Assurance) Committee shall. consist of a minimum of.The Medical Director/designee.implement appropriate plans of action to correct identified quality deficiencies.regularly review and analyze data.At a minimum, the QAPI program will: address all systems of care and management practices.Considerations include, but are not limited to: Certain classes of medications, such as antipsychotics, which could identify trends.In an interview on 10/30/25 at 8:21am, Durable Power of Attorney (DPOA) EE reported she did not feel the facility provided Resident #102 with individualized dementia care even though she had provided the facility with interventions that helped reduce the resident's stress responses. DPOA EE reported the facility had recently added several psychotropic medications to Resident #102's medication list and she felt this could have been avoided if the staff had provided individualized care.In an interview on 10/30/25 at 12:57pm, Registered Nurse (RN) N reported she worked on the dementia care unit where Resident #102 resided and had observed that some staff members did not know how to provide interventions to reduce the resident's stress responses. RN N reported she mentioned her concerns to a member of the management team, but that staff member was no longer employed at the facility, and the facility had not taken action.In an interview on 10/27/25 at 12:57pm, Licensed Practical Nurse (LPN) U reported she cared for Resident #102 regularly. LPN U described Resident #102 as hard to handle, and that he could be very mean and scary. LPN U reported she was not sure what triggered Resident #102 when he became upset.In an interview on 10/29/25 at 1:40pm, former Social Worker (SW) H reported the QAPI committee did not review or analyze data or develop a plan of action when areas of concern were identified, including the quality of care and the activities program in the dementia care unit.In an interview on 10/30/25 at 1:14pm, Nursing Home Administrator (NHA) A reported he was the QAPI Coordinator for the facility, but he limited records of any ongoing data the QAPI committee reviewed and analyzed.In an email with a reference date of 10/29/25 at 2:31pm, Nursing Home Administrator (NHA) A asked if the QAPI plan was the same as the QAPI policy he had already provided to this writer.Review of a document labeled QAPI Plan provided by NHA A on 10/29/25 at 3:02pm, with a reference date of 2024, revealed Introduction The QAPI Plan of (name of facility was blank) .Vision.no information provided, Mission.no information provided, Purpose.no information provided, Guiding Principles. no information provided. In an interview on 10/30/25 at 3:16pm, Nursing Home Administrator (NHA) A reported the facility had a large turnover in within the management team since April 2025 and as a result QAPI had not been running smoothly. When queried regarding data the QAPI committee routinely analyzed to ensure quality care, NHA A stated the necessary reports were not being generated due to the management staff turnover, including monitoring of the use of psychotropic medications. NHA A reported concerns related to the quality of care in the dementia unit had been discussed but a PIP had not been developed. NHA A then stated, We need to do a PIP on Dementia Care. NHA A reported the facility was not aware of any non-compliance related to the use of psychotropic medications until the survey that ended on 10/30/25. NHA A reported the committee was aware of deficient practice related to staff performance evaluations and staff training, but a Performance Improvement Plan (PIP) had not been implemented.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review the facility failed to ensure the medical director or their designee attended Quality Assurance and Performance Improvement (QAPI) meetings at least quarterly, resulting in the potential for the decline in overall medical care provided and decreased oversight of the implementation of resident care throughout the facility.Findings include:Review of the facility's QAPI committee sign-in sheets revealed neither the medical director nor their designee physically or virtually attended a committee meeting from April-August 2025. In an interview on 10/30/25 at 3:16pm, Nursing Home Administrator (NHA) A reported the facility had a large turnover in within the management team since April 2025 and as a result QAPI had not been running smoothly. NHA A reported the facility also changed Medical Directors in April and the former Medical Director did not attend QAPI as required. NHA A reported the new Medical Director was agreeable to attending but needed to have it scheduled in advance and that initially lead to them not attending the meeting as required.Review of the facility's policy Quality Assurance Performance Improvement (QAPI) with a reference date of 6/2025 revealed Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. Policy Explanation and Compliance Guidelines.2. The QAA (Quality Assessment and Assurance) Committee shall be interdisciplinary and shall: a. Consist of a minimum of.ii. The Medical Director or his/her designee, b. Meet at least quarterly.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review the facility failed to maintain an effective training program which included training in resident rights, quality assurance, infection control, compliance and ethics, and communication for all existing employees, resulting in the potential for decreased resident safety for all residents who resided in the facility.Findings include:In an interview on 10/30/25 at 12:47pm, Director of Nursing (DON) B reported the facility used a computer-based training platform for staff training for a portion of the year but after the facility opted to stop using the platform/paying for the service, it was no longer able to access record of any training the staff had completed. DON B reported there was no current staff training program in place.In an interview on 10/30/25 at 1:14pm, DON B reported any training the staff completed would be recorded in their employee file.Review of employee files for CNA T, X and KK revealed no training related to the QAPI program, Infection Control, Compliance and Ethics, Communication or Resident Rights in the last 12 months.In an interview on 10/30/25 at 3:16pm, Nursing Home Administrator (NHA) A reported the facility had not been tracking staff training and was aware some staff training requirements had not been met. NHA A reported there was no Performance Improvement Plan in place to correct the lack of annual staff training.Review of a Facility Assessment with a reference date of 8/1/25 revealed Training Program Evaluation Our facility's training program includes .ongoing training for.existing staff.consistent with their expected roles. We complete an educational needs assessment and develop a curriculum and training plan based on staff need and resident characteristics. The content at a minimum includes Effective communication, Resident rights.Infection Control.QAPI (Quality Assurance and Performance Improvement), Compliance and ethics.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to implement an effective in-service training program for nurse aides that supported mandatory nurse aide attendance, tracked participation, and ensured continuing competence for 3 Certified Nurse Aides (identified as CNAs T, X, and KK) of 3 CNAs whose in-service training files were reviewed, resulting in the potential for unmet resident care needs. Findings include:Review of a Nurse Aide Training Program policy with a reference date of 10/28/25 revealed Policy: The facility maintains an appropriate and effective nurse aide in-service training program for the purpose of ensuring the continuing competence of nurse aides. In an email on 10/29/25 at 3:28pm, documentation of Certified Nursing Assistant (CNA) in-service training for the last 12 months was requested for CNA T, X and KK.In an interview on 10/30/25 at 12:47pm, Director of Nursing (DON) B reported the facility had been without a staff educator and she was trying to cover the responsibilities of that role. DON B reported she was working on developing a staff training plan and had not put trainings in place at this time. DON B reported the facility previously used a computer-based system for staff training but was no longer using that platform for training and could not access any staff training records.In an interview on 10/30/25 at 12:51pm, Business Office Manager (BOM) BB reported it was her responsibility to maintain each staff member's personnel file. BOM BB confirmed the documentation present in the personnel files for CNAs T, X and KK did not reflect the required 12 hours of annual training.In an interview on 10/30/25 at 3:16pm, Nursing Home Administrator (NHA) A reported he was aware the facility was not in compliance with providing CNAs 12 hours of training per year. When further queried, NHA A reported the facility did not currently have a staff training plan.Review of The Importance of Continuing Education Credits in Healthcare, www.leaderstat.com, 2024, revealed: According to The Institute For Health Care Improvement, CE (continuing education) is a vehicle for spreading best practices and how to improve patient outcomes.