STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235358	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Ludington	1000 East Tinkham Avenue Ludington, MI 49431

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2646749 Based on interview and record review the facility failed to appropriately stabilize 1 resident after a fall (R93), out of 2 residents reviewed for falls, resulting in increased pain, transfer to the hospital, and death. Findings:Resident #93 (R93)Review of an admission Record reflected R93 admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, osteoarthritis, spondylosis without myelopathy or radiculopathy (age-related degeneration of the spine involving disc wear and bone spurs without spinal cord compression), wedge compression fracture of T5-T6 (thoracic vertebra), and multiple fracture of ribs, bilateral. Review of a Nursing Evaluation Summary dated [DATE] reflected, (R93) was educated on call light use and the importance of using the call light system and the importance of calling for assistance, however, she has continuously been getting herself out of bed and into the bathroom on her own without calling for assistance. Education on fall risk and safety has been provided.Review of an IDT (Interdisciplinary) Progress Note dated [DATE] reflected R93 had low O2 (oxygen) saturation and had been very fatigued with confusion and anxiety . (R93) has had 2 falls today, does not ask for assistance, self-transfers. Will move to room closer to desk. Review of a Pertinent Charting - Skin note dated [DATE] indicated R93 sustained a small gash from recent fall and hitting side of face. Review of a Nurses' Notes dated [DATE] reflected (R93) had another fall in her bathroom after attempting to get up and transfer to bathroom on her own; (R93) developed a small gash under R (right) eye and a goose egg on forehead.Review of a Nurses' Notes dated [DATE] at 9:34 PM reflected (R93) continues to be agitated and SOB (short of breath). Constantly standing up and trying to walk to BR (bathroom) or climbing out of bed and wheelchair. Resident was toileted and had dinner but continued to be agitated.Review of a Nurses' Notes dated [DATE] at 1:23 AM reflected, Resident (R93) was told not to leave her wheelchair without assistance. When everyone was gone, she moved from her wheelchair to a sedentary chair, the tried to move back to wheelchair and landed on her Rt (right) side on the floor. Assessed resident and her Rt hip was causing her pain. Got her up by maxi lift (a machine used to lift totally dependent residents in a sling) and put to bed. Still complaining of hip pain called (physician) and they wanted her sent to hospital for x-ray.Review of an Un-witnessed Fall incident report dated [DATE] reflected Resident (R93) moving from her chair to wheelchair and wheelchair moved and caused resident to fall on her Rt side. Complaints of Rt hip pain putting any pressure on it causes her to cry out in pain. Got her in Maxi lift and put to bed. Where she is non-stop rubbing her Rt hip. The incident report indicated R93 was sent to the hospital. During a telephone interview on [DATE] at 5:31 AM, Registered Nurse (RN) U reported R93 was sitting near the (nurse) desk in a chair and no one was with her when she fell. RN U said R93 complained of her leg hurting. RN U said she assessed R93 by working from the head down, palpating the body and asking if R93 hurt anywhere. RN U reported R93 only cried out in pain at her hip. RN U said that R93 was lifted off the floor into her wheelchair and then from the wheelchair into bed with a maxi lift. RN U reported R93 complained of increased pain after being transferred and was sent to the hospital within 30 minutes of the fall due to the severity of the pain. RN U reported that it is facility policy to use a maxi lift to transfer anyone who falls in the facility. Review of a hospital Imaging Report dated [DATE] reflected (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Per (Long Term Care Facility) report, (R93) had unwitnessed fall, was found down. (Long Term Care Facility) used hoyer lift to get (R93) up, states (R93) cried of hip pain while they used the lift. When asked where they picked (R93) up from (Long Term Care Facility) gave 4 different locations of possibility. (R93) c/o (complained of) hip pain, unsure which hip. (R93) poor historian. The imaging report indicated that R93 was diagnosed with a Minimally displaced intertrochanteric fracture of the right hip. Further review of the hospital records dated [DATE] reflected R93 was transferred to a bigger hospital for evaluation, was not optimized for surgery and admitted to end of life care. Review of a Certificate of Death reflected R93 died on [DATE] Due to (or as a consequence of) Medical complications of right hip fracture. Approximate Interval Between Onset and Death: Days.During an interview on [DATE] at 8:17 AM, the Director of Nursing reported that after a resident falls the first priority is to rule out abuse and then the nurse would do a head to toe assessment. The DON said starting with the head and neck, assess for skin tears, bruising, immediate redness or obvious deformities. If the resident does complain of leg pain you would assess for evenness and not move the resident from the floor because it could worsen the injury. The nurse would call 911 and wait for EMS (emergency medical services) to arrive and ensure the resident was transferred safely. The DON reported it is not the facility policy to use a full lift to move residents after a fall.

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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 interview and record review, the facility failed to implement an effective and current system of surveillance of staff illnesses to identify possible communicable diseases and infections to prevent the spread of an illness/outbreak for 2 of 18 residents (Residents #35 and #59) and all residents residing in the facility, reviewed for infection prevention and control.Findings:Employee Line ListReview of the February Infection Surveillance Report revealed:A Registered Nurse called off of work for GI with an onset date of 2/2/26.An Activities Staff Member called off of work for GI with an onset date of 2/9/26.A Registered Nurse called off of work for GI with an onset date of 2/11/26.A Certified Nursing Assistant called off of work for Other with an onset date of 2/13/26.A Certified Nursing Assistant called off of work for GI with an onset date of 2/13/26.A Certified Nursing Assistant called off of work for Other with an onset date of 2/16/26.An office staff member called off of work for Other with an onset date of 2/16/26.There was no documentation of the unit(s) the staff members worked on or residents they came in contact with. There was no description of the GI symptoms experienced or follow-up documentation for other. There was no tracking of housekeeping staff or therapy staff.During an interview on 03/11/2026 at 2:10 PM, Infection Control Preventionist (ICP) A reported that she was responsible for tracking facility outbreaks for employees and residents.ICP A reported that employee call-off slips were sent to HR (human resources) and were then emailed to her. The call-offs were reviewed daily and tracked on her computer system. Once an employee called off, she would determine, based on their symptoms, when they could return to work. ICP A reported that if the call-off slip did not include the symptoms the staff member was experiencing, she would just put sick and would follow up when they returned to work. ICP A reported that on her employee line list, she did not include the date they last worked or the unit they were assigned. ICP A reported she did not track call-offs/illnesses for housekeeping staff or therapy staff despite their direct and/or close contact with residents. ICP A was not aware that there had been multiple staff call-off's related to GI (gastrointestinal) illness. When presented with the information that there had been multiple staff GI call-offs, ICP A reported that some staff would call-off for symptoms that she did not believe they were experiencing.Resident #35 (R35)Review of an admission Record revealed R35 was a [AGE] year-old female, admitted to the facility on [DATE].Review of R35's Order Summary dated 2/17/26 revealed, Imodium A-D Oral Tablet 2 MG (Loperamide HCl) Give 1 tablet by mouth every 4 hours as needed for diarrhea for 3 Days.Review of the Practitioner Communication Log located at the nurses' station revealed a handwritten note dated 2/17/26 that R35 was experiencing congested cough + diarrhea-Imodium?Review of R35's Practitioner Note dated 2/17/26 revealed, .History of Present Illness: Cough, congestion, diarrhea for 1 day.Review of R35's Order Summary dated 2/17/26 revealed, Imodium A-D Oral Tablet 2 MG (Loperamide HCl) Give 1 tablet by mouth every 4 hours as needed for diarrhea for 3 Days.Resident #59 (R59)Review of an admission Record revealed R59 was a [AGE] year-old female, admitted to the facility on [DATE].Review of the Practitioner Communication Log revealed a handwritten the following notes:2/11/26 R59 has had diarrhea for days with a handwritten note beneath Why didn't anyone call for Imodium?2/16/26 R59 c/o (complains of) diarrhea-wants Imodium.Review of R59's Progress Note dated 2/17/26 revealed, .Order received for.Imodium r/t (related to) c/o diarrhea.Review of R59's Order Summary dated 2/17/26 revealed, Imodium A-D Oral Tablet 2 MG (Loperamide HCl) Give 1 tablet by mouth every 4 hours as needed for diarrhea for 3 Days.During an interview on 03/11/2026 at 2:10 PM, ICP A reported that for the residents, she kept an active line listing for residents experiencing any symptoms of infection. ICP A reported residents were added to the line list following her daily review of the 24-hour report daily. Nursing notes and PRN (as needed) medication administration were included in the 24-hour report which allowed her to identify any residents experiencing symptoms of an infection/illness. ICP A was asked if she had identified a potential GI (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	outbreak for residents to which she stated, that's not ringing a bell. R35 and R59, residing on the same unit, received an order for Imodium on 2/17/26 for similar GI symptoms. Their GI symptoms were not listed on the line list and the potential for an outbreak was not investigated.Review of the facility policy, Infection Prevention and Control Program last reviewed/revised 12/27/23 revealed, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment Performance Improvement. c. Licensed nurses participate in surveillance through assessment/evaluation of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered in accordance with physician orders for 2 of 8 residents (Resident #6 and #8) reviewed for nursing professional standards of practice.Findings:Resident #6 (R6) Review of an admission Record revealed R6 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety. Review of R6's Order Summary dated 8/13/26 revealed, LORazepam (Ativan) Tablet 0.5 MG Give 0.25 mg by mouth in the morning for anxiety Give 1/2 tab in the morning. Review of R6's Order Summary dated 8/12/26 revealed, LORazepam Tablet 0.5 MG Give 0.5 mg by mouth at bedtime for anxiety Give 1 tab PO at bedtime. Review of R6's Control Substance Record revealed that on 2/14/26 at 7:30 PM and 2/15/26 at 8:30 PM, R6 was dispensed Ativan 0.25 mg (1/2 tablet). Review of R6's February Medication Administration Record revealed that on 2/14/26 at 7:30 PM and 2/15/26 at 8:30 PM Ativan 0.5 mg (1 tablet) was documented as administered. Review of R6's Electronic Medical Record revealed no documentation pertaining to the incorrect doses of Ativan (0.25 MG) administered on 2/14/26 or 2/15/26. During an interview via email on 03/11/2026 at 1:24 PM, the Director of Nursing (DON) was provided with the information listed above with a request for documentation to invalidate the medication error. The DON confirmed R6's medication error on 2/14/26 or 2/15/26 and stated she, Initiated occurrence reports and will follow up with nurse education per policy. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, The seven rights of medication administration include the right medication, right dose, right patient, right route, right time, right documentation, and right indication. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 705). Elsevier Health Sciences. Kindle Edition. Resident #8 (R8)Review of an admission Record reflected R8 admitted to the facility with diagnoses that included paroxysmal atrial fibrillation (an irregular heart rhythm often caused by damage to the heart's electrical system). Review of R8's February 2026 Medication Administration Record reflected an order for Digoxin Tablet (a prescription medication used to treat heart failure and arrhythmias) 125 MCG (microgram) Give 1 tablet by mouth at bedtime for heart failure Hold if HR (heart rate) less than 60 (beats per minute) – Start Date- 11/10/2025. The MAR reflected the medication had been administered each day in February. No pulse was recorded on the MAR in the spaces provided. Review of R8's March 2026 MAR reflected the same digoxin order with the same parameters to hold if HR less than 60. The MAR revealed the medication was administered without recording a heart rate in the spaces provided March 1-March 8, 2026. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Pulse Summary from January-March 2026 did not reflect R8's pulse was taken at the time of medication administration daily as ordered. During an interview on 3/11/2026 at 11:35 AM, the Director of Nursing (DON) reported that it would be a standard of care to assess a resident's pulse prior to administering Digoxin. The DON said the pulse (heart rate) should be recorded on the MARs but the order was entered incorrectly.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #: 2652909 and 2646749Based on interview and record review, the facility failed to provide sufficient staff with the knowledge and skills sets to support and assist residents experiencing agitation and confusion and implement meaningful behavioral interventions for 5 of 18 residents (Residents #67, #19, #91, #57, and #85), reviewed for behavioral health needs.Findings:Review of a Complaint Investigation Report dated 10/17/25 the following anonymous complaint, Complainant states that there are quite a few residents with mental health issues on the floor that aren't safe, and they should not be in this facility Complainant states that management should be coming in to assist when there are not enough staff present, but they don't .Resident #67 (R67)Review of an admission Record revealed R67 was a [AGE] year-old male, admitted to the facility on [DATE].Review of a Minimum Data Set (MDS) assessment for R67, with a reference date of 2/8/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R67 was cognitively intact. During an interview on 3/9/26 at 2:20 PM, R67 reported that R19 should not be a resident at the facility as he was verbally aggressive towards staff and residents. R67 reported that R19 has been caught urinating outside in front of others, yells at people from the community that are walking by while he's smoking, does not follow smoking rules, refuses to bathe, frequently uses profanity directed at staff and residents, and attempts to intimidate the staff and residents in order to get what he wants. R67 reported feelings of frustration, annoyance, and discontentment with R19's behaviors in the facility and his perception that the facility staff were not making attempts to get control of his behavior or find other placement for R19.Resident #19 (R19)Review of an admission Record revealed R19 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: alcohol dependence with withdrawal, anxiety disorder, and cognitive communication deficit.Review of R19's late entry Social Services Progress Note dated 1/31/26 but created on 2/20/26 revealed, Per nursing report, on 1/30/26 resident was noted being inappropriate and using offensive language directed toward staff/peers. SSD met with resident on 1/31/26 to address the above with limited results. Resident has hx (history) of similar behaviors and is noted to be dismissive and easily frustrated when approached by staff. Resident presents w/ (with) limited insight, poor impulse control skills, and is at times hard to redirect.Staff continue to closely monitor resident and utilize the following interventions: redirection, reassurance, firm limit-setting, and distraction.The facility did not initiate enhanced supervision and R19's Care Plan was not updated with interventions for his new behavior of offensive language directed towards residents.Review of R19's late entry Social Services Progress Note dated 2/6/26 but created on 2/20/26 revealed, Per nursing report, resident reported w/ physical aggression on 2/6/26, specifically throwing an object when frustrated. No injuries reported. Resident has hx of behavioral dysregulation associated with poor impulse control skills. SSD met with resident 1:1 on 2/9/26 to address the above. Resident presents calm with no additional reports of physical aggression. SSD continues to meet with resident w/ emphasis on coping skills, calming techniques, firm limit-setting, and appropriate expression of needs/frustrations. Staff continue to closely monitor for any changes in mood/behaviors, offering immediate interventions as indicated.The facility did not initiate enhanced supervision and R19's Care Plan was not updated with interventions for his behaviors of physical aggression and throwing objects.Review of R19's Pertinent Charting-Behavior dated 2/8/26 revealed, Resident was backing up in his wheelchair down the hall in front of south nurse's station. This nurse heard resident say, move you f***ing c**t, Another resident was in their wheelchair behind the resident, (R19) was trying to back up into the other resident. This nurse intervened and was able to move the other resident safely. (R19) yelled, stating I asked her nicely to move. This nurse and other south nurse had conversation with (R19), letting him know this behavior is (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inappropriate, and that he can't talk to people like that, or attempt to push people out of the way. (R19) verbalized understanding, stating I asked her 5 times.The facility did not initiate enhanced supervision and R19's Care Plan was not updated with interventions for his new behavior of aggressive physical contact with other residents.Review of R19's Social Services Progress Note dated 2/18/26 revealed, Per nursing report, resident noted on 2/18/26 with inappropriate toileting (urinating in non-designated area). Resident has hx of poor judgment and behavioral concerns. SSD addressed behavior with resident with emphasis on hygiene, and appropriate toileting practices. Staff continues to closely monitor resident reinforce facility policies and provide reminders, cueing, monitoring, and redirection.The facility did not initiate enhanced supervision and R19's Care Plan was not updated/modified with interventions for his behavior of urinating in inappropriate areas. R19's urinating in non-designated areas care plan had not been updated with new interventions since 10/24/25.During an interview on 03/11/2026 at 12:05 PM, Social Service Director (SSD) S reported R19 has many behaviors and he frequently uses profanity at staff stating if staff look at him the wrong way and he says something. SSD S reported R19's behavior of using profanity at other residents had not been reported as verbal abuse. SSD S reported that a verbal altercation could be considered a form of abuse and it should have been investigated. SSD S reported she did not know what the follow-up was for his behavior of swearing at other residents.SSD S reported that interventions for his behaviors are redirection, limit setting, reality setting, identifying the root cause of frustration and changing out staff that have a better relationship with R19.During an interview on 03/11/2026 at 5:08 PM, SSD S reported that her progress note dated 1/31/26 was from secondhand information and could not confirm that R19 had used profanity at other residents. Regional Director of Operations (RDO) C reported that she would discuss with R19 alternate placement with less restrictions that may be a better fit for him. RDO C reported she would also look into his ability to be his own decision maker.Resident #91 (R91)Review of an admission Record revealed R91 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia with severe agitation and behavioral disturbances.Review of a Complaint Investigation Report dated 10/17/25 the following anonymous complaint, .Complainant states that (R91) is very violent, and he resides in the Northeast Unit. Complainant states that (R91) has severe dementia, and he is supposed to be a one-on-one assist. Complainant states that (R91) has gone through the facility and smacked/kicked/punched residents and staff. Complainant states that it is unknown if residents have sustained injuries from this. Complainant states that (R91) pulls his pants down and pees in other residents' rooms while the residents are in there .Review of R91's behavior Care Plan initiated on 10/8/26 revealed, Resident has behavior(s) related to (SPECIFY: diagnosis/reason) as evidenced by: exit seeking, physically aggressive toward staff, resident uses 3-4 word sentencesReview of R91's IDT-Interdisciplinary Progress Note dated 10/8/2025 revealed, Resident having sundowners behaviors in the evening. Walking towards front door and attempting to exit in view of staff, they prevented any exiting. Was being combative with staff and was a 1:1 for a short time last night.The facility did not initiate enhanced supervision and R91's Care Plan was not updated with interventions for increased agitation/behaviors in the evening despite R91 requiring 1:1 supervision for a short time.Review of R91's IDT-Interdisciplinary Progress Note dated 10/10/2025 revealed, Resident is a 5 day hospice respite. Has confusion and behaviors. Increased behaviors in the evening/at night. Not redirectable. Social worker to speak to family about more appropriate placement.The facility did not initiate enhanced supervision and R91's Care Plan was not updated with interventions for increased agitation/behaviors in the evening.Review of R91's Pertinent Charting-Behavior note dated 10/10/2025 revealed, Continuously going into other residents' rooms. Pushes and slaps staff when they try to redirect. Resident is very confused and is unable to follow directions.The facility did not initiate enhanced supervision and R91's Care Plan was not updated with interventions to prevent R91 from entering other residents rooms.Resident #57 (R57)Review of an admission Record revealed R57 was a [AGE] year-old male, admitted to the facility on [DATE].Resident #85 (R85)Review of an (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission Record revealed R85 was a [AGE] year-old female, admitted to the facility on [DATE].Review of an Incident Investigation Report dated 10/11/25 revealed, At approximately 7:30 pm on 10/11/25, (nurse-name omitted) called (name omitted), the Administrator and notified him the (R91) has had increased behaviors and struck (R57) in the forearm while holding a spoon as well as enter the rooms of (R1) and (R85) while naked. (R91) was immediately redirected and placed on a one on one. (R85) saying, Get out, get out of here. I turned around and saw (R91) in the room in front of (R85) with no shirt on, and his pants pulled down just above his knees. (R91) was approximately 2 - 3 ft into the room just staring at (R85). (R85) stated to me that she could tell someone was there that wasnt supposed to be, and that's why she was yelling for him to get out. I ran over to pull his pants up and redirected him back to his room.Investigation Summary: The investigation found that (R91) was assisted by staff back to his room, and the nurse placed her medication cart across from his door for increased supervision. (R91) was placed on a 1 on 1 for increased supervision.Review of R91's behavior Care Plan revealed revisions were completed following the incident of resident to resident abuse: .Staff 1:1 with resident revised on 10/11/25 Resident has behavior(s) related to (diagnosis/reason) as evidenced by: exit seeking, physically aggressive toward staff, verbal out bursting, rejection of care, refuses medications, wanders into other rooms. revised on 10/23/25Review of the Facility Assessment last updated 9/12/25 revealed the facility was assessed and able to care for, .Mental health and behavior (Specific Care or Practices) Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Ludington	1000 East Tinkham Avenue Ludington, MI 49431

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2646749Based on observation, interview and record review, the facility failed to provide timely care to one (Resident #33) of three residents reviewed for dignity. Findings: Resident #33 (R33) Review of a Face Sheet revealed R33 was an [AGE] year-old male, last admitted to the facility on [DATE], with pertinent diagnoses of dementia and a stroke that caused weakness to the left side of his body. R33 was dependent on one staff person for all activities of daily living. During an observation on 3/09/26 at 10:02 AM, R33 laid in bed resting with his eyes closed, knees bent, and his heels resting on the mattress. The room smelled strongly of feces. R33 laid in a large, dried area of diarrhea. During an interview on 3/09/26 at 10:15 AM, Certified Nurse Aide (CNA) F reported not checking on R33 since arriving on the unit at 7:00 AM. CNA F stated that she had not yet gotten to R33 due to being the only CNA on the north-east hall this am and the high acuity levels. During an observation on 3/09/26 at 10:22 AM CNA F and Registered Nurse (RN) H provided care to R33 and indicated that the stool was dried to R33's skin and this has been here quite a while. R33's buttocks were red and non-blanchable with no open areas noted.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to designate a representative was supported and accurately recorded in the medical record for 1 of 8 residents (Resident #27) reviewed for resident rights.Findings:Resident #27 (R27)Review of an admission Record revealed R27 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: congestive heart failure, type 2 diabetes, lymphedema, and severe morbid obesity.Review of a Minimum Data Set (MDS) assessment for R27, with a reference date of 3/9/26 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated R27 was cognitively intact. Review of R27's Care Plan dated 9/8/23 revealed, Resident plans to stay long-term in the Skilled Nursing Facility.Actively involve the resident/family in the resident's plan of care.Encourage on-going involvement with family and friend(s).Review of R27's admission Record on 3/10/26 at 2:24 PM revealed that R27's niece (Family Member [FM] P) was documented as his Responsible Party-Clinical and Emergency Contact #1.During an interview on 03/11/2026 at 8:09 AM, Licensed Practical Nurse (LPN) O reported that R27 had gone downhill and declined since his return to the facility following his hospitalization. Indicating a need for increased family involvement in decision-making and care planning.Review of R27's Standards of Care Meeting dated 2/27/26 revealed R27 had a pressure injury identified upon readmission to the facility (readmitted on [DATE]).Review of R27's Standards of Care Meeting revealed R27 sustained a fall on 02/24/2026 at 5:30 PM. FM P was not notified of R27's fall.Review of R27's Electronic Medical Record revealed no documentation that FM P was notified of R27's pressure injury or fall.Review of R27's Advance Directive dated 2/11/26 revealed R27 had signed Durable Power of Attorney paperwork appointing FM P to make health care decision when he was no longer able to make decisions on his own.Review of R27's Palliative Care Note dated 2/13/26 revealed, There is an advance directive on file in (hospital computer system). This document names (FM P) as his sole health care advocate. When speaking with family, I shared my impression, in the (R27) does not appear that he's able to make his own medical decisions; however, I made family aware that a capacity assessment would have to be done by the Primary team.During an interview on 03/11/2026 at 11:47 AM, R27 reported that he wanted his niece (FM P) to be his medical and financial decision maker. R27 reported that prior to his hospitalization (from 2/10/26-2/20/26) the facility was to notify his niece of any medical concerns. R27 reported that he signed documentation when he was at the hospital for his niece to become his Durable Power of Attorney (DPOA) even though he was still cognitively intact. R27 reported that he wanted his niece to be involved with both his medical and financial decisions as he felt he was unable/unfit to manage his care and finances independently any longer.R27 reported that he would have expected the facility to notify his niece of his fall and his skin breakdown stating, that's what I signed for believing the documentation he signed at the hospital had activated her status as his DPOA. R27 confirmed that had been no discussion of FM P assuming the role of patient advocate following his readmission to the facility.During an interview on 03/11/2026 at 12:05 PM, Social Service Director (SSD) S reported she was not aware that R27 had signed Advance Directive paperwork at the hospital or his preference to have FM P more involved in his decision making and care.Review of R27's Electronic Medical Record revealed no documentation that the facility discussed with R27 his wishes to have his niece more involved and act as his patient advocate with both his financial and medical decisions following his return from the hospital. There was no documentation that his care plan was updated to reflect his preferences and/or goals for his niece and her increased participation in his care. There was no documentation that the facility provider addressed the palliative care note regarding his ability to make his own medical decisions.Review of R27's Care Plan initiated on 12/5/23 revealed, Focus-Resident has chosen not to formulate advanced care planning. Goal- Resident's preference will be honored through next review.(continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Target Date: 03/13/2026. Interventions. Periodically review choice for no advanced care planning with resident/family.Review of R27's admission Record received from the Director of Nursing on 03/11/2026 at 10:23 AM revealed FM P was no longer listed as R27's Responsible Party-Clinical and was now only listed as Emergency Contact #1.Review of the Facility Assessment last updated 9/12/25 revealed, .Offer and assist resident and family caregivers (or other proxy as appropriate) to be involved in person-centered care planning and advance care planning .Review of the facility policy Fall Prevention Program last reviewed/revised 10/26/23 revealed, .6. When any resident experiences a fall, the facility will. d. Notify physician and family.Review of the facility policy Pressure Injury Prevention and Management last reviewed/revised 1/1/22 revealed, .e. The goals and preferences of the resident and/or authorized representative will be included in the plan of care.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, For patients experiencing acute or chronic illnesses, diseases, or trauma, patients' family members and surrogate decision makers become active partners in decision making and care .When possible, patients and family caregivers want to participate in shared decision making about treatment options and ongoing symptom management. Incorporating a patient's and family's cultural beliefs, values, and communication patterns is essential to provide individualized patient/family-centered care. When developing a plan of care, consider all resources available to patients. The family plays a key role .Engaging the family or designated surrogate is a fundamental skill of patient-centered care [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: 2646749Based on interview and record review, the facility failed to 1.) implement the facility policy for pressure injury prevention and management 2.) ensure pressure injury assessments were comprehensive and accurate, and 3.) ensure treatments were ordered and completed for 1 of 2 residents (Resident #27) reviewed for pressure injury prevention and management.Findings:Resident #27 (R27)Review of an admission Record revealed R27 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: congestive heart failure, type 2 diabetes, lymphedema, and severe morbid obesity. Further review of R27's admission Record on 3/10/26 at 2:24 PM revealed that R27's niece (Family Member [FM] P) was documented as his Responsible Party-Clinical and Emergency Contact #1.Review of a Minimum Data Set (MDS) assessment for R27, with a reference date of 3/9/26 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated R27 was cognitively intact. Review of a Complaint Investigation Report dated 10/17/25 the following anonymous complaint, Complainant states that (R27) resides in the Northeast Unit. Complainant states that (R27) is obese, and the staff don't want to get him up because he is very big.so he has to lay in bed.Complainant states that he (R27) wants to be able to get out of bed.Review of R27's Occupational Therapy Note dated 3/4/26 revealed, .Bed Mobility Roll left and right=Dependent Review of R27's ADL (Activities of Daily Living) Care Plan revealed, Resident is dependent on staff for mobility Date Initiated: 06/11/2024.Review of R27's skin Care Plan revealed, .Encourage resident to reposition self if able Date Initiated: 09/08/2023. Encourage/assist as needed to elevate heels off the mattress as tolerated. Revision on: 12/05/2024. heel protector bilateral feet as tolerated. Revision on: 07/28/2025.Review of R27's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 2/20/26 revealed a score of 14, indicating R27 was at moderate risk for the development of a pressure injury. Sensory Perception: Slightly limited. Moisture: Very moist. Activity: Bedfast. Resident is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition: Adequate. Friction and shear: No apparent problem.During an observation on 03/09/2026 at 10:33 AM, R27 was in bed, on his back, with no repositioning devices (offloading wedge, pillow) in place.During an observation on 03/09/2026 at 2:31 PM, R27 was in bed, on his back, with no repositioning devices in place.During an observation on 03/09/2026 at 3:57 PM, R27 was in bed, on his back, with no repositioning devices in place.During an observation and interview on 03/10/2026 at 8:15 AM, R27 reported that staffing was an issue, reporting that there were insufficient staff and they don't get me up. R27 reported that following his readmission to the facility he was receiving therapy services stating, therapy wants me up and therapy was more effective when I'm out of bed. R27 stated he would get sore sitting in bed all the time and reported he had sores on his buttocks. R27 reported he needed assistance with repositioning stating he would ask for assistance with offloading/repositioning but it doesn't always get done. R27 was in bed on his back with no repositioning devices in place. There was a thin pillow on the floor between his bed and the window and wedges on his dresser. R27's heel protecting boots had fallen almost entirely off of his feet and were not protecting his heels (his heels were directly on the mattress.)During an observation and interview on 03/10/2026 at 1:38 PM, R27 was in bed on his back with no repositioning devices in place. His heel protectors were not in place, and his heels were directly on the mattress. R27 confirmed that he had not been repositioned or out of bed.During an observation on 03/10/2026 at 4:15 PM, R27 was in bed on his back with no repositioning devices in place. His heel protectors were not in place, and his heels were directly on the mattress.During an interview on 03/11/2026 at 8:09 AM, Licensed Practical Nurse (LPN) O reported that she and another staff member just boosted R27 up in bed for breakfast. LPN O reported that R27 had some skin breakdown on his left upper posterior thigh/lower left buttocks. LPN O reported that R27 required (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with repositioning in bed and reported that R27 had gone downhill (declined) since his hospitalization from 2/10/26-2/20/26. LPN O reported that the CNAs (certified nursing assistants) were to reposition R27 every couple hours and reiterated that R27 required a lot of assistance with his care/repositioning. LPN O did not report that R27 would refuse care.During an observation on 03/11/2026 at 9:09 AM, R27 was in bed on his back. There was a thin pillow under his right side. He had heel protectors on, but he was positioned low in the bed, and his feet were resting on the footboard.Review of R27's Nursing readmission Evaluation dated 2/20/26 revealed R27 had a left buttock pressure injury. There was no assessment of R27's wound. (Per the Fundamentals of Nursing, comprehensive wound assessments are to include location, dimensions, description of wound bed, exudate type, exudate amount, presence of odor, wound edges, peri-wound assessment, tunneling/undermining, and pain.)Review of R27's Skin Assessment dated 2/20/26 revealed a new abnormal skin area on his left buttock-open area.Treatment initiated? Yes.Review of R27's Nursing readmission Evaluation dated 2/21/26 revealed R27 had a left buttock pressure injury and a sacral pressure injury.Review of R27's Skilled Charting dated 2/21/26 revealed his skin was intact.Review of R27's Skilled Charting dated 2/22/26 revealed R27's skin was not intact but only referenced Skin tears, abrasions, bruises. Pressure ulcer-any stage was not checked.Review of R27's Electronic Medical Record (EMR) revealed no documentation that the provider or FM P were notified of the newly identified pressure injuries on 2/20/26, 2/21/26, or 2/22/23.Review of R27's Order Summary and Treatment Administration Record revealed no new treatments initiated for the pressure injuries on 2/20/26, 2/21/26, or 2/22/23.Review of R27's Wound Assessment revealed no documentation that measurements, a wound description, or pictures were obtained for the pressure injuries on 2/20/26, 2/21/26, or 2/22/23.Review of R27's Skin Issues dated 2/23/26 revealed, Skin Issue: #001: New skin Issue. Location: Left Gluteal Fold. Issue type: Pressure ulcer / injury. Progress: New: new wound. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin loss. Wound was present on admission. Painful: Yes. Wound pain (Frequency): At dressing. Pain description: Sharp. Wound pain interventions: Change in position . Length (cm): 0.85 Width (cm): 1.34 Depth (cm): 0.1.primary dressing: Medi honey Secondary dressing: Foam. Additional care: Incontinence management.Heel suspension/Protection device.Moisture control.Turning/repositioning program.Skin issue notification: Provider. Skin issue notification: Manager.Review of R27's Order Summary and Treatment Administration Record revealed, Cleanse left buttock with gauze and NS (normal saline), apply medihoney, and apply a 4x4 bordered foam dressing in the evening with a start date of 2/23/26. (3 days after the pressure injury was identified).Review of R27's Order Summary with a start date of 2/24/26 revealed, Cleanse wound to left buttock with normal saline and wound cleanser, pat dry, apply thin layer of Medi honey to wound bed, cover with a 2x2 silicone foam dressing. Followed by barrier cream around dressing every evening shift AND as needed.Review of R27's skin Care Plan on 3/10/26 at 3:00 PM revealed, Focus-Resident is at risk for impaired skin integrity related to severe morbid obesity, incontinence, DM (diabetes mellitus), CHF (congestive heart failure), PVD (peripheral vascular disease), lymphedema, history of healed pressure, venous and DM ulcers, prefers to be in bed most of the time. Revision on 06/11/2024.Interventions-assist with Turn and re-position upon rising, before and after meals, prior to bed, with care rounds during the night, and as resident allows. Revision on: 02/23/2026 and 03/05/2026. However, that intervention had been implemented and in place since 12/05/2024. R27's Care Plan did not reflect a turning/repositioning program following the wound assessment on 2/23/26 as directed.Review of R27's Skilled Charting dated 2/23/26 revealed R27's skin was not intact but only referenced Skin tears, abrasions, bruises. Pressure ulcer-any stage was not checked.Review of R27's Skilled Charting revealed no assessment was completed on 2/24/26.Review of R27's Skilled Charting dated 2/25/26 revealed his skin was intact.Review of R27's Skilled Charting dated 2/26/26 revealed R27's skin was not intact but only referenced Skin tears, abrasions, bruises and MASD (moisture acquired skin damage [i.e., rash, redness]). Pressure ulcer-any stage was not checked.Review of R27's Standards of Care Meeting dated 2/27/26 revealed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27 had a pressure injury identified upon readmission to the facility (readmitted on [DATE]). Provider notified? No. Responsible party notified related to wound(s)? No. Readmit with pressure area from hospital dr (doctor) notified on admission. wound care orders in place. Air mattress in place. Resident tends to favor that side.Review of R27's Skilled Charting dated 2/27/26 revealed his skin was intact.Review of R27's Skilled Charting dated 2/28/26 revealed his skin was intact.Review of R27's Skilled Charting revealed no assessment was completed on 3/1/26.Review of R27's EMR revealed he did not receive a dietary consult until 3/2/26 and the consult did not reference R27's pressure injury.Review of R27's Skin Issues dated 3/2/26 revealed, Skin Issue: #001: Skin issue is resolved.Review of R27's Skin Assessment dated 3/2/26 revealed, Lft (left) buttock wound, tx is in place. Indicating ongoing skin breakdown.R27's skin Care Plan focus was updated on 03/05/2026 to include prefers to not be repositioned, prefers to lean to the left side. Confirming R27's care plan was not updated with new interventions following the identification of the pressure injury. Only the focus was updated 13 days after the identification of the pressure injury.Review of R27's Skin Assessment dated 3/9/26 revealed, Lft buttock tx in place.Review of R27's Order Summary dated 2/23/26 revealed, Cleanse left buttock with gauze and NS, apply medihoney, and apply a 4x4 bordered foam dressing in the evening. This order was not discontinued until 3/10/26, indicating an ongoing area of breakdown.Review of R27's Bed Mobility Task revealed that from 2/20/26-3/10/26 R27 consistently required Extensive Assistance (resident involved in activity, staff provide weight-bearing support) to Total Dependence (Full staff performance).Review of R27's Bladder Elimination revealed that from 2/20/26-3/10/26 R27 was incontinent of urine for every entry except for 1 entry on 3/7/26 (increasing his risk of further skin breakdown).Review of R27's Bowel Elimination revealed that from 2/25/26-3/10/26 R27 was incontinent of his bowels for every entry except for 4 entries on 3/3/26, 3/4/26, 3/7/26, and 3/10/26 (increasing his risk of further skin breakdown).Review of R26's EMR revealed no documentation that R27 would refuse to be repositioned.During an interview on 03/11/2026 at 11:47 AM, R27 reported that his niece is his decision maker for medical and financial concerns. R27 reported that prior to his hospitalization (from 2/10/26-2/20/26) the facility was to notify his niece of any medical concerns. R27 reported that he wanted his niece to be involved with both his medical and financial decisions as he was unable to manage his care and finances independently any longer. R27 reported that he would have expected the facility to notify FM P pressure injuries upon his readmission to the facility. R27 reported that he continued to experience soreness on his buttocks.During an interview via email on 3/11/26 at 10:23 AM, the DON provided a Skin Timeline which revealed: 2/9/26 Resident had house ointment (zinc) to ischium buttocks.2/20/26 readmitted to the facility. admission skin assessment noted areas to Lt (left) buttock. Resident continued with house ointment (zinc).(confirming there was no treatment change for the newly identified pressure injury/worsening of the pressure injury).2/23/26 Wound nurse re-evaluated and per picture and measurements, wound remains unchanged and does not support stage 3 or decline in wound. Wound has 0.1 (cm) depth and no slough; not indicative of stage 3.N.O. (new order) received for wound treatment (confirming the delay in treatment).2/27/26 IDT (Interdisciplinary Team) reviewed and completed Wound SOC (Standards of Care). (The wound SOC did not identify the multiple contradicting notes regarding R27's pressure injury).3/2/26 Skin area closed within 11 days (confirming inaccurate assessments with Skin Assessment dated 3/9/26 showing ongoing concern OR ongoing breakdown with treatment continued from the order dated 2/23/26 until 3/10/26).3/5/26 IDT reviewed and completed Wound SOC.Review of the facility policy Pressure Injury Prevention and Management last reviewed/revised 1/1/22 revealed, .2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 4. Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform a comprehensive root cause analysis and implement meaningful interventions/preventative measures following a fall for 1 of 9 residents (Resident #27) reviewed for accidents and hazards.Findings:Resident #27 (R27)Review of an admission Record revealed R27 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: congestive heart failure, type 2 diabetes, lymphedema, and severe morbid obesity. Further review of R27's admission Record on 3/10/26 at 2:24 PM revealed that R27's niece (Family Member [FM] P) was documented as his Responsible Party-Clinical and Emergency Contact #1.Review of a Minimum Data Set (MDS) assessment for R27, with a reference date of 3/9/26 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated R27 was cognitively intact. Review of R27's Witnessed Fall incident report dated 2/24/26 revealed: Incident Description: Resident was on his right side with staff on both sides of his bed. This LPN (Licensed Practical Nurse [LPN] O) was changing the bandage on his left hip on the left side of his bed and his CNA (Certified Nursing Assistant [CNA] R) was on his right side. Resident said he was slipping then fell over his bed to the floor. CNA blocked the fall with his body as he slide (sic) to the floor. Was put back in bed with a hoyer lift. Said I told you I was slipping. Said his back hurt. Complaint of pain 8 out of 10 in his back. When asked if he wanted to be evaluated at the hospital he said no. Just took evening Norco prior to the fall. Given PRN Tizanidine for back spasms. Left toe had a skin tear. Toe was washed and bandaged. Doctor notified and ordered a back x-ray.Root cause: body habitus, air mattress, resident position in bed (prefers left side, was on right side).Intervention: monitor residents' position while doing treatments to reduce the risk of sliding and falling.Statement: (CNA R) He was assisting in turning resident so nurse could do dressing change. Resident was rolled to the right side. (CNA R) was standing right next to him holding him, he states the resident was holding the mobility bar and his belly area came over the edge of the air mattress and his legs started to come off the bed and the resident slid down the side of the bed, (CNA R) attempted to buffer the fall and assisted to lower him to the floor. The nurse attempted to come around the bed to help but it happened pretty fast.Review of R27's Standards of Care Meeting dated 2/25/26 revealed, Resident was in his bed getting dressing change to left hip. There was a nurse on his left side and a CENA on his right side. Resident stated he was slipping. He then slid out of bed to the floor. CENA blocked the fall with his body and the resident slid to the floor onto his stomach. Root cause: body habitus, air mattress, resident position in bed.Fall Follow Up Actions: Monitor resident's position when doing treatments to reduce the risk of sliding/falling.Name of Responsible Party Notified/Updated related to fall(s): (R27). FM P was not notified of the fall.Review of R27's fall Care Plan last revised 2/25/26 revealed, Resident is at risk for falls/injury related to dependent with transfers, morbid obesity, non ambulatory, weakness, legally blind, history of falls.Monitor resident's position during treatments to reduce the risk of sliding/falling. No other interventions were implemented.Review of R27's skin impairment Care Plan revealed, .APM (alternating pressure mattress) to bed Date Initiated: 09/11/2025. There were no specific details for the settings of the mattress.During an observation and interview on 03/11/2026 at 11:52 AM, R27's alternating pressure mattress was set on alternate every 10 minutes. There were options for alternate, Static, and Max Firm. The weight was set for 660 pounds. (R27's weight on 2/21/26 was 335.4 pounds) R27 was in bed on his back. Because of R27's size, there was minimal space between his left and right side and the edge of the bed, thus impeding the staff's ability to turn and reposition R27 due to lack of bed surface area.Review of R27's APM manufacturer's guideline revealed an option for static mode and max firm mode. Max Firm-Press to set the air mattress in quick inflation mode, which facilitates nursing and caring.During an interview on 3/11/26 at 11:58 AM, LPN O reported that she was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completing a dressing change on one side of R27's bed and CNA R was on the other side holding him on his right side. LPN O reported that she believed that while he was on his side, he repositioned his legs causing one leg to go over the side of the bed and once that leg was over the edge of the bed gravity took over and caused him to fall. LPN O reported that she felt R27 needed a bigger bed because of his large size and the difficulty staff had with safely rolling him to his side away from the edge of the bed.During an interview on 03/11/26 2:30 PM, LPN O confirmed that R27 had an alternating pressure mattress. LPN O reported she was not aware of and had never used other modes on the mattress. LPN O reported she had never been told to use other functions. (static mode or max firm-stops the alternating movement and evenly distributes the support surface. Minimizing resident movement during treatments/care.)During an interview on 03/11/2026 at 3:55 PM, CNA R reported that he was assisting LPN O with R27's dressing change on 2/24/26 by holding R27 on his right side. CNA R reported they rolled him as usual which was difficult based on his large size and the inadequate size of the bed. CNA R reported there was minimal room to roll him because his body took up the entirety of the bed. CNA R reported that typically if a resident is to be rolled, they are pulled towards the opposite way they are to roll in order to keep them at the center of the bed. However, they were unable to do that for R27 which left him turned/positioned directly at the edge of the bed. CNA R reported that there was a slight change in his position which caused just enough of a shift that R27 fell off of the bed. CNA R was unable to determine if the shift was caused by the resident's movement or if the alternating pressure mattress caused the position change. CNA R reported that the CNAs do not touch the pressure settings of the mattress and he had not set it to any other modes. CNA R reported that R27 needed a larger bed to prevent another fall because there's no room to roll him.During an observation and interview on 03/11/2026 at 11:47 AM, R27 vividly remembered his fall and stated, it hurt me and still scares me now. R27 stated that at the time of his fall I told them to pay attention because I was slipping and then I hit the ground. R27 reported he felt that he could experience another fall because they (facility staff) haven't changed anything and haven't done anything different. R27 reported that he felt he needed a bigger mattress or additional side rails at his feet so my legs don't fall off. R27 reported that he would have wanted and expected the facility to notify his niece of his fall.During an interview on 03/11/2026 at 4:42 PM, Regional Director of Operations (RDO) C reported that R27 preferred his pressure mattress firm, and the Director of Nursing (DON) had documented a progress note and updated R27's care plan to reflect his preference.Review of R27's Nurses Note written by the DON and dated 3/11/26 at 2:22 PM revealed, Spoke with resident along with maintenance regarding his air mattress. Asked if he was comfortable on it and he stated yes he was. Asked if he felt it was too firm or too soft and he replied it's in the middle, asked if he was just right and he said yes. He stated he didn't want it changed it was just right and to keep it where it's at as he is comfortable with it.Review of R27's skin impairment Care Plan revealed, Focus.Requests APM mattress to be left on current setting at firm side for his comfort. Revision on: 03/11/2026.Adjust air mattress setting per resident request and comfort Date Initiated: 03/11/2026. There were no specific details for the settings of the mattress.Review of the facility's alternating pressure mattress selection (received 3/11/26 at 4:54 PM) revealed, .Routinely check the mattress and pump to ensure proper function, inflated properly, and the pump is set to alternating pressure with the static function used only for care.Review of the facility policy Fall Prevention Program last reviewed/revised 10/26/23 revealed, .4. When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program. 5. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 6. When any resident experiences a fall, the facility will. d. Notify physician and family. e. Review the resident's care plan and update as indicated.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Positioning begins on one side of the bed so that turning to other side does not cause patient to roll toward edge of bed. [NAME] RN, MSN, PhD, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Air-assisted devices have a limitation. Once a transfer begins, the friction-reduction capability contributes to an increase in momentum, making it more difficult to stop the transfer. Use caution to be sure the patient does not slide beyond or even off the stretcher or bed . [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Specialty Air Beds: Bed surface material slippery; patients can easily slide down mattress or out of bed when being transferred. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to include the Interdisciplinary Team (IDT) and psychiatric provider in the process of the gradual dose reduction of an antipsychotic medication for 1 of 5 residents (Resident #83) reviewed for psychotropic medication use.Findings:Resident #83 (R83)Review of an admission Record revealed R83 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia with agitation with psychotic disturbances.During an observation on 03/09/2026 at 10:33 AM, R83 was observed in the hallway loudly yelling, I want to get out! She continued to yell in the hallway and self-propelled herself in her wheelchair across the hall and attempted to enter room [ROOM NUMBER]. The resident in room [ROOM NUMBER] stated R83 was always yelling and attempting to enter other rooms. The resident reported her behaviors were constant.Review of R83's Psychiatry Follow-up note dated 1/13/26 revealed, GDR quetiapine (seroquel) 25 mg tablet. Diagnosis: Dementia with associated psychotic and/or agitated behaviors. Symptom(s): Other: agitation, yelling, wanting to leave.Practitioner response: A gradual dose reduction is contraindicated.In an effort to maintain behavioral symptoms this medication will be continued.I feel that the benefits of this medication outweigh the risks of adverse events for this resident.In an effort to maintain the current efficacy of Quetiapine and Donepezil and avoid the potential risk of an escalation in behaviors this medication will be continued.Review of R83's Physician Recommendations signed by the physician on 1/13/26 revealed, Quetiapine 25mg BID (twice a day) and 50mg HS (at night) for Dementia with associated psychotic and/or agitated behaviors since being increased 07/24/25.Resident with good response, maintain the current dose as a dosage reduction would likely cause unnecessary distress for the resident.Review of R83's Order Summary dated 1/15/26 revealed, QUEtiapine Fumarate (Seroquel) Oral Tablet 25 MG-Give 2 tablet by mouth at bedtime AND QUEtiapine Fumarate Oral Tablet 25 MG-Give 1 tablet by mouth in the morning.Review of the Physician Communication Binder located at the nurses station revealed a handwritten entry on 2/10/26 for R83 that (psychiatry consultation group) rec (recommends) GDR seroquel to 25mg BID (twice a day).Review of R83's Electronic Medical Record revealed no documentation that the contracted psychiatry group completed an assessment on R83 in February 2026.Review of the Physician Communication Binder revealed a handwritten entry on 2/11/26 for R83 Please don't reduce her seroquel again. She was miserable.Review of R83's Practitioner Note dated 2/12/26 revealed, .(R83) is an [AGE] year-old hospice patient with dementia with agitation and anxiety. She takes sertraline, Seroquel, Aricept, and Ativan.(Contracted psychiatry group) is recommending a gradual dose reduction of her Seroquel from 25 mg in the morning and 50 mg at bedtime to 25 mg twice daily. She has a history of a failed gradual dose reduction of Seroquel. We will monitor her anxiety, agitation, and psychosis .Review of R83's Pertinent Charting-Change in Condition note dated 2/13/26 revealed, Change identified: GDR of SeroquelAssessment: GDR Seroquel from 25mg po in am and 2 tabs at bedtime, changed to Seroquel 25mg po BID (twice a day).Review of R83's Order Summary dated 2/13/26 revealed, SEROquel Oral Tablet 25 MG Give 1 tablet by mouth two times a day.During an interview on 03/11/2026 at 12:05 PM, Social Service Director (SSD) S reported that the psychiatric consultation group conducts assessments and gives recommendations to either attempt a GDR or that a GDR would be contraindicated. SSD S confirmed that R83 had recently failed a GDR of seroquel and stated that the facility would not necessarily attempt again after a failed one and a decision would be made with the interdisciplinary team and the resident's representative to attempt the GDR again. SSD S reported she was unable to locate the psychiatric consultation groups recommendation from February but did recall discussing another attempt to GDR R83's seroquel in a recent behavioral meeting.During an interview on 3/11/2026 at 1:42 PM, Regional Director of Operations (RDO) C and SSD S reported that a GDR of R83's seroquel was attempted in (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	December and in January it was determined that R83 had failed the reduction. At that time, R83's seroquel was increased to 25mg in the morning at 50mg at bedtime.During an interview on 03/11/2026 at 5:08 PM, RDO C confirmed that there was no psychiatric consultation completed in February for R83 and was unable to determine where the recommendation that the facility physician referenced originated or any other correlating documentation.During an interview on 03/11/2026 at 9:55 AM, Family Member (FM) T reported that he had noticed over the last month that R83 was less calm and more talkative. FM T reported he had noticed that R83 had been attempting to get out of her wheelchair more frequently. FM T reported he was aware of the recent GDR of seroquel in February and reported he felt more comfortable have the physician and management staff make the decisions on the appropriateness of the GDR stating, I leave it up to them to make the decisions they are the professionals.Review of R83's Pertinent Charting-Behavior dated 3/6/26 revealed, Behavior Displayed: restless, agitated, going in other residents room, bothering other residents.Precipitating factors/events: res (resident) kept going in other res room and bothering res by getting into their things and not wanting to leave their things alone, going up to other res and bothering them by constantly talking to them and when the res says they dont want to talk or doesnt respond res keeps on or trys (sic) to run into them with her wheelchair, or wont quit talking to them, res bothering res in the DR (dining room) by going around to the tables and talking and being disruptive.Intervention(s) attempted: res removed to a different table and redirectedIntervention results: res kept bothering/upsetting them by constantly (sic) talking and not being quiet when asked, res kept quiet once her food tray arrived.Review of the facility policy Use of Psychotropic Drugs and Gradual Dose Reductions last reviewed/revised 10/24/22 revealed, .Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated.3. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team.15. For any individual who is receiving a psychotropic medication to treat expressions or indications of distress related to dementia, the GDR may be considered clinically contraindicated for reasons that include, but that are not limited to: a. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and 16. The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain dental services to replace a missing lower denture in a timely manner for 1 resident (R10) out of 1 resident reviewed for dental services.Resident #10 (R10)Review of an admission Record reflected R10 admitted to the facility on [DATE] with diagnoses that included osteoporosis without current pathological fracture, depression and anxiety.Review of a Care Plan Report initiated on 10/15/2024 R10 has a dental problem related to being edentulous, with a goal of reduced complications related to dental/oral issues. Interventions included in the Care Plan included Refer to dental services as needed.During an interview on 3/09/2026 at 10:12 AM, R10 states that she lost the lower denture when she accidentally put them on a meal tray and they got thrown away. R10 indicated the Nursing Home Administrator (NHA) is aware and told her he wanted to wait to see what Medicaid would cover. R10 reported it's been a long time since she lost her lower denture, and she does not like to eat around others because of how she has to chew her food. Review of a Quality Assurance Form dated 1/7/2025 indicated (R10) reported she dropped her dentures yesterday and they broke. The form indicated that the lower denture could not be found and an appointment was made for 2/20/2025 at a dental clinic. It was not clear if the lower dentures were ever located. Review of a Quality Assurance Form dated 8/20/2025 indicated Bottom dentures lost-resident left them on a tray and didn't realize it, now they're gone. Was choking on the dentures at the time and took them out. About 3 months ago (when the dentures were lost). The Findings indicated the NHA Spoke with R10 about replacement of the dentures. Facility contacted dental office on getting a quote to see if Medicaid will cover replacement. If insurance will not cover, will reach out to the [NAME] to see if financial assistance if available. The dietitian wrote a note that reflects R10 had not had any unplanned weight loss as a result of the missing denture. Review of an email communication between the facility and the dental clinic dated 11/25/2025 (two months after the second concern form was created) reflected the dental clinic provided a ledger of R10's denture creation in 1/5/2024 as an estimate. Review of another email communication between the facility and the dental clinic dated 12/5/2025 reflected .Regarding (R10). We are trying to replace (R10's) bottom set of dentures for her as they are suspected to have gotten thrown away. I was wondering if there is any way you can send me an invoice just for those bottom dentures. The facility would really like to get them replaced for her but administration is asking for an invoice before we are able to do so. If you have any questions, please feel free to email or call me. I will be glad to help in any way I can. The reply from the dental clinic was received on 12/8/2025 that indicated the clinic was not able to print an invoice for a patient that did not have an outstanding balance. During an interview on 3/11/2026 at 11:40 AM, the Director of Nursing (DON) reported the facility would be responsible for replacing the lower denture if it had been thrown out after being put on a meal tray. During an interview of 3/11/2026 at 3:00 PM, the NHA reported that he did not have any evidence of communication with the tribal leaders related to financial assistance for replacing the denture.Review of a facility policy Dental Services revised 10/30/2023 reflected Routine and 24-hour emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. 6. The facility will promptly refer residents with lost or damaged dentures for dental services. Social Service staff/dietary manager or designee will document what was done to ensure the resident could still eat and drink adequately while awaiting dental services and will describe extenuating circumstances around the delay. 7. The facility shall no charge a resident for the loss or damage of dentures when it is determined to be the facilities responsibility. Circumstances when the loss or damage of dentures is the facility's responsibility are: a. facility staff personally handling, cleaning, or storing dentures when they are lost or damaged.