STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235361	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Niles Care Center, LLC	911 S 3rd St Niles, MI 49120

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the published menu was served as planned and residents were consistently informed in advance of any menu changes affecting all residents consuming food from the kitchen resulting in resident dissatisfaction with their meal experience and feelings of frustration related to meals. Findings include:During an interview on 1/21/2026 at 10:02 AM, Dietary Supervisor (DS) Q stated that they serve the main meal and there was an always available menu for the residents that didn't like the main meal served. Review of the always available menu revealed cheeseburger, hot dog, salad, tomato or chicken noodle soup, grilled cheese, peanut butter and jelly.During an observation on 1/22/2026 10:55 AM, the menu posted in the main dining room for lunch was onion sage chicken, au gratin potatoes, carrot medallions and spice cake. The week at a glance menu for 1/22/2026 was onion sage chicken, au gratin potatoes, carrots and upside-down spice cake.During an observation and interview on 1/22/2026 at 11:51 AM, the lunch on the tray line was observed to be au gratin potatoes and medallion carrots. When asked where the onion sage chicken was, Dietary [NAME] (DC) U stated that she was asked by DS Q to mix the chicken into the potatoes so she made it into a casserole. It was observed that there was hardly any chicken cut up and put into the potatoes and was approximately 1 ounce (oz) per serving instead of the recommended 3 oz protein serving size. When asked what the residents on mechanical soft diets would receive, DC U said that they would get the same carrots. When further queried since the carrots were hard on the steam table and they were getting ready for lunch service, DC U stated that they had to be cooked more so they could be softer for the mechanical soft diets and proceeded to take some out and cook it longer. DC U [NAME] said she usually made sure mechanical soft menu items were available but the carrots were hard to cook and she thought it was okay to serve. During an interview on 1/22/2026 at 12:05 PM, Registered Dietitian (RD) CC stated that the same meal was served to all residents except for some special tweaks such as for no added salt (NAS) diets, no salt packet was given, and for carbohydrate-controlled diets (for diabetics), instead of a dessert a fruit cup was given. At 1/22/2026 at 12:07 PM, it was noted that DS Q pulled out the menu spreadsheet for the day and went over what to serve mechanical soft diets, NAS diets and diabetic diets with the DC U and the dietary aide since they weren't sure what to serve. During an interview on 1/22/2026 at 12:07 PM, DM Q stated that the facility didn't have the correct amount of chicken so he told DC U to mix the au gratin potatoes with the chicken into a casserole. When asked about the menu board in the main dining room not being updated with this change, DS Q said he wasn't aware it had to be changed since the cook used the same food items and made it into a casserole. DS Q also stated that the cooks generally gave the same vegetables to mechanical soft residents as regular, they just cook the vegetables longer to where they are very soft. During a confidential Resident Council meeting on 1/23/2026 at 11:05 AM, 1 resident stated that the kitchen changed the menus quite a bit and sometimes they would let them know about the changes and sometimes they didn't. During another interview on 1/22/2026 at 1:05 PM, DS Q stated that the cook didn't cook enough chicken for the meal so he told her to make a casserole instead. DS Q said he was unaware that there wasn't enough protein for the lunch meal since they didn't cook enough chicken. When discussing the menu (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	spreadsheets and whether they were being followed for quantities needed and for the therapeutic diets, DS Q reported that they don't follow the therapeutic diet if there was one and they usually alter consistencies with whatever is available or make the food soft. DS Q also stated that he changes the menus often from what the dining company RD makes since he knew what the residents prefer but he had to remember to change the menu board when he did that. During an interview on 1/22/2026 at 4:42 PM, Nursing Home Administrator (NHA) A stated that she wasn't aware of the menu not being followed in the kitchen, staff not knowing what to serve mechanically altered diets and diabetics, and the menu spreadsheets not being followed.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to honor resident food choice preferences in 1 resident (Resident #37) of 3 residents reviewed for food preferences and didn't have enough food supply according to 2 residents (Resident #16, Resident #19) resulting in the increased likelihood for decreased food acceptance and frustration in not getting what they wanted to eat.Findings include:Resident #37 (R37)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R37 initially admitted to the facility on [DATE] and her Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R37 was cognitively intact.During an interview on 1/21/2026 at 11:14 AM, R37 stated that the food is horrible so she ordered the same thing for dinner every night-2 hamburger patties with no bun and dessert. R37 stated that she wanted English Muffins but had to buy her own because the kitchen wouldn't get it for her. R39 also said that she liked tomatoes on salad and more vegetables to be served. R37 stated that she talked to Dietary Supervisor (DS) Q about her preferences in the past but she was still unhappy.Resident #16(R16)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R16 admitted to the facility on [DATE] and his Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R16 was cognitively intact.During an interview on 1/21/2026 at 12:03 PM, R16 stated that the kitchen ran out of food a lot especially when the end of the month was near. R16 said that the kitchen ran out of brown sugar, butter, bananas and peach cups often. During another interview on 1/22/2026 at 9:56 AM, R16 stated that the kitchen had run out of hot dogs and hamburgers for a week before and it is supposed to be available since it's on the always available menu. R16 also said that the kitchen served food that no one liked and they didn't have condiments available. Resident #29 (R29)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R29 admitted to the facility on [DATE] and his Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R29 was cognitively intact.During an interview on 1/22/2026 at 1:06 PM, R29 stated that the kitchen ran out of hotdogs and hamburgers a lot. He said they also ran out of pudding and bananas, especially from the middle to the end of every month. Review of the always available menu revealed cheeseburger, hot dog, salad, tomato or chicken noodle soup, grilled cheese, peanut butter and jelly.During an interview on 1/21/2026 at 10:02 AM, Dietary Supervisor (DS) Q stated that he talked to the residents to get their food preferences. DS Q said they have the main meal and an always available menu for the residents that didn't like the main meal served. During an interview on 1/22/2026 at 12:07 PM, DS Q and RD CC stated that food orders came from 2 different food sources and they came on Thursdays and Fridays which was how it had always been and corporate wouldn't allow only 1 food company to deliver food. DS Q reported that he ordered the food for the week and then it went to the corporate level and they adjusted items from there to make sure they stayed in budget. When asked what DS Q does when they didn't have food in the kitchen, he stated that he went to the store and picked up any items he needed. DS Q stated that he didn't hear the residents talking about the kitchen running out of food and if they did it usually took 1-2 days to get the food in. RD CC stated that they have run out of brown sugar and haven't had it available since corporate took it off to stay in budget. During another interview on 1/22/2026 at 2:30, DS Q reported that they have run out of bananas before but they always had fruit cup, applesauce, and blueberries for an option. DS Q also said that he obtained food preferences from residents and he would talk to R37 again about her food preferences. During an interview on 1/22/2026 at 4:42 PM, Nursing Home Administrator (NHA) A stated that food orders were done by DS Q and then it went to a third party and they made changes as needed. NHA A stated she wasn't aware that residents said that food was running out by the middle to end of each month. Review of the Food Preference Policy with an adoption date of 7/11/2018 revealed .8. If the resident refuses or is unhappy with his or her (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diet, the staff will create a care plan that the resident is satisfied with.10. The Food Services Department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night.

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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 that Quality Assessment and Process Improvement (QAPI) meetings had the Medical Director (MD) and the Infection Preventionist (IP) as mandatory attendees at least quarterly resulting in the potential for the MD and the IP to not be notified of quality deficiencies occurring in the facility.Findings include:Review of the QAPI Committee Adaptation and Attendance Record dated 1/28/2025, 4/25/2025 and 7/29/2025 revealed that the MD DD did not attend the meetings.Review of the QAPI Committee Adaptation and Attendance Record showed that there wasn't a meeting in September 2025 and November 2025 and the IP did not attend the meeting on 10/30/2025.During an interview on 1/23/2026 at 9:42 AM, MD DD stated that he tried to attend QAPI every month whether it was in person or by phone because he wanted to know what was going on in the facility in all the different areas. MD DD said he couldn't remember the dates that he wasn't at QAPI and stated that if he didn't sign the sheet then he didn't attend. During an interview on 1/23/2026 at 1:10 PM, Nursing Home Administrator A stated that they have QAPI meetings monthly to ensure that the required attendees such as the MD and IP attend quarterly. This surveyor reviewed the dates that the MD and IP were not at the QAPI meetings and NHA A nodded and said that there have been changes in management including her this past year. Review of the Quality Assessment and Assurance Program 9/18/2019 revealed .Required Members: Administrator serves as chairperson, Director of Nursing, Medical Director or other attending physician designated by the facility, at least three (3) other staff members, at least one must be the administrator, owner, a board member or other individual in a leadership roleInfection Control and Prevention Officer . Expectations of the Committee: QAPI is an ongoing process rather than a once a quarter event.The QAPI committee meets monthly. Committee members are required to attend regularly scheduled meetings. In the event that Committee members are unable to attend meetings, arrangements are made for a designee to present required work, data, reports and progress on issues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the necessary infection control measures for residents at risk based on physician orders and standards of infection control for 4 residents (Resident #63, #55, #15 and #13) of 7 residents reviewed for infection control practices, resulting in the potential for transmission of MDRO (multidrug-resistant organisms) and an increased risk of infections to a vulnerable population. Findings include:Resident #63 Review of an admission Record revealed Resident #63 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: obstructive uropathy (blockage in urine flow) and urogenital implant (indwelling foley catheter). Review of Resident #63's Physician Orders revealed, Maintain Foley catheter with 16 Fr 5cc balloon every shift.Start date 1/14/26 at 2:30 PM, Wound care for R (right) hallux (big toe) . Start date: 1/14/26, Enhanced Barrier Precautions (includes gown and gloves for high-contact resident care activities) for wound and foley catheter every shift for patient monitoring.Start date 1/14/26. During an observation on 01/21/2026 at 2:02 PM Resident #63's room was posted with signage indicating Enhanced Barrier Precautions (EBP) were in place and during transfers (direct care) that staff should wear a gown and gloves. Observed foley catheter tubing and a drainage bag attached to the bedframe and Resident #63's right foot observed wrapped with gauze. Certified Nursing Assistant (CNA) J and Registered Nurse (RN) P were preparing to transfer the resident from wheelchair to bed. Both staff were wearing gloves but did not have gowns on. RN P wrapped the gait belt around Resident #63's waist, then another facility staff entered the room and alerted RN P and CNA J to put gowns on. The staff both paused care to obtain gowns but there were no gowns in the resident's room or hanging on the door with the gloves. During an observation on 1/22/26 at 10:21 AM in Resident #63's room, Certified Occupational Therapy Assistant (COTA) BB was preparing to transfer the resident from bed to wheelchair and was wearing gloves but no gown. COTA BB wrapped the gait belt around Resident #63 and helped him to the edge of the bed. COTA BB stood in front of Resident #63 and wrapped her arms around him, holding onto the gait belt and assisted him to stand and pivot into the wheelchair. COTA BB then unhooked Resident #63's foley catheter bag from the bed frame and positioned it underneath the wheelchair. COTA BB discarded her gloves and wheeled Resident #63 out of the room. In an interview on 1/23/26 at 11:32 AM, Director of Nursing (DON) B reported that the facility holds a monthly all staff meeting that includes infection control and EBP reminders. DON B reported that staff are expected to wear gowns and gloves during every direct care activity, including transfers. DON B reported that staff should have both gowns and gloves available for use on the resident's door. DON B reported that staff are monitored by herself and other members of the management team. DON B reported that she could not confirm that COTA BB received the most recent infection control education. Review of the CDC (Centers for Medicare & Medicaid Services) Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Memorandum (Ref: QSO-24-08-NH) with an effective Date of April 1, 2024 revealed, .The new guidance related to EBP is being incorporated into F-880 Infection Prevention and Control .GUIDANCE Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following: .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, .Wound care: any skin opening requiring a dressing . Resident #55 Review of an admission Record revealed Resident #55 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, weakness, constipation, need for assistance with personal care. Review of Resident #55's Care Plan revealed, .FOCUS: (Resident #55) requires extensive assistance with bed mobility.total assistance with oral hygiene, personal hygiene, toileting hygiene, and showering/bathing.FOCUS: .at increased risk for alterations in skin integrity r/t incontinence of bowel and bladder, impaired mobility. Date initiated: 12/16/16.Interventions: .Precautions for prevention of pressure ulcers will be implemented, such as good peri-care and drying of (Resident #55's) skin, apply protective barrier cream.Date initiated: 9/8/18 .FOCUS: .incontinent of bowel and bladder. Date initiated: 10/12/16.Administer appropriate cleansing and peri-care after each incontinent episode. FOCUS: .at risk for UTIs (urinary tract infections) r/t incontinence of bowel and bladder, impaired mobility, and needs extensive total assistance with care. Date initiated: 9/10/24.FOCUS: .alteration in elimination due to bowel and bladder incontinence. Date initiated: 3/10/25. Interventions: .Provide incontinence care after incontinence episode PRN (as needed). Date initiated: 3/10/25 . During an observation on 01/22/2026 at 2:33 PM in Resident #55's room CNA J and CNA W were preparing to transfer the resident into bed and provide incontinence care. Observed incontinence care for Resident #55 by CNA J. Resident #55's incontinence brief was observed saturated and heavy with urine. CNA J performed the incontinence care using disposable wipes to clean the resident's front groin folds and then the buttocks; observed BM (bowel movement) between the buttocks and on the disposable wipes during incontinence care. Staff did not clean the resident's genital folds or between the resident's legs. CNA J did not change gloves or perform hand hygiene; with the same gloves CNA J opened the resident's nightstand drawer, used the bed controls and handed Resident #55 her call light. CNA J touched clean surfaces with contaminated gloves. In an interview on 1/22/26 at 2:50 PM, CNA J was unsure of the facility expectations regarding glove use and hand hygiene related to incontinence care. In an interview on 1/23/26 at 11:32 AM, Director of Nursing (DON) B reported that incontinence care should include thoroughly cleaning the folds of the female genitals, gloves should be changed after contact with BM, and barrier cream should be used with every incontinence episode. Review of the Centers for Disease Control website (https://www.cdc.gov/handhygiene/providers/index.html) last revised on June 25, 2018 revealed, When to Perform Hand Hygiene .After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings .After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient .If hands will be moving from a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contaminated body site to a clean body site during patient care .Wearing gloves is not a substitute for hand hygiene. Dirty gloves can soil hands .Steps for Glove Use .Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face) .Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Failure to remove gloves after caring for a patient may lead to the spread of potentially deadly germs from one patient to another. Resident #15 (R15) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R15 initially admitted to the facility on [DATE] with pertinent diagnoses including right knee with Methicillin Resistant Staphylococcus Aureus (MRSA) infection. Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 which indicated R15 was cognitively intact. During an observation on 1/21/2026 at 11:03 AM, R15's door had a sign printed from the Centers for Disease Control (CDC) that revealed STOP: CONTACT PRECAUTIONS. Everyone must: clean their hands, including before entering and leaving room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. During an interview on 1/21/2026 at 12:06 PM, Licensed Practical Nurse (LPN) M reported to this surveyor as surveyor was donning (putting on) gown and gloves and getting ready to enter R15's room that R15 had a wound and it was unnecessary to wear PPE if someone was going to her room to talk to her. This surveyor asked LPN M if R15 had an active infection and she stated that she didn't know. Then, on 1/21/2026 at 12:15 PM, LPN came to the door of R15's room while surveyor was in there talking to R15 and stated that R15 had an active infection with MRSA and PPE was required. During an interview on 1/21/2026 at 12:10 PM, R15 stated that she had an infection in her knee and showed this surveyor her knee. R15 said that staff didn't always wear PPE when they were in her room and took care of her. During an observation and interview on 1/21/2026 at 12:39 PM, Dietary Supervisor (DS) Q took R15's lunch tray to R15 in her room without wearing any PPE. When asked about the sign on door, DS Q stated that he should have worn a gown and gloves when entering the room and apologized. Then, DS Q was observed telling all other staff on 400 Hall that were passing trays that any sign on the door meant they had to wear PPE when delivering meal trays. During an interview on 1/21/2026 at 1:01 PM, Certified Nursing Assistant (CNA) T stated for residents under contact precautions, PPE such as a gown and gloves weren't needed if you were just talking to the residents and passing water to them. CNA T said it was the same as Enhanced Barrier Precautions (EBP). During an interview on 1/22/2026 at 4:24 PM, Licensed Practical Nurse Manager (LPNM) K stated that R15 was under contact precautions due to an infected wound on her knee and that PPE such as gown and gloves were to be donned when entering the room unless you were just talking to her then there was no need for PPE. During an interview on 1/22/2026 at 4:27 PM, Wound Nurse (WN) D stated that R15 was under contact precautions due to an infected wound on her knee and that PPE such as gown and gloves were to be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	donned when taking care of her but if you weren't touching or going near her bed, PPE wasn't needed. WN D also said you can enter the room without PPE if you were taking care of R15's roommate. Review of R15's Care Plan revealed .Focus: I have an alteration in my skin integrity. I came to the facility after a left knee replacement surgery and my wound has delayed (sic) healing. I have a diagnosis of MRSA to my wound site. Date initiated 7/17/2016. Focus: I am on contact isolation due to MRSA in left knee. Date initiated 10/3/2024. Review of Physician orders revealed .Contact isolation related to MRSA in wound. Every shift. Active 3/23/2025. During an interview on 1/22/2026 at 4:37 PM, Director of Nursing (DON) B stated that anytime there was an active infection such as with MRSA, COVID and flu, a resident needed to be on contact precautions and PPE such as a gown and gloves needed to be donned. DON B said if you're not touching anything in resident area then you don't need any PPE. Review of the Contact Precaution Policy with an updated date of 2/22/20221 revealed . Procedure.2. Gloves and Hand Hygiene: A. Hand hygiene should be completed prior to donning gloves. B. Gloves should be worn when entering the room AND while providing care for the resident. 3. Gowns: A. A gown should be donned prior to entering the room .6. Contact Precautions May Be Considered for (Examples): A. Multi-drug resistant organisms (e.g., MRSA.) . Resident #13 Review of an admission Record revealed Resident #13 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dysphagia (difficulty or inability to effectively swallow) and major depressive disorder (persistent depressed mood or loss of interest in activities causing significant impairment in daily life). Review of a Minimum Data Set (MDS) assessment for Resident #13 with a reference date of 1/2/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 00/15, which indicated the resident was severely cognitively impaired. Section K of the MDS revealed Resident #13 received all of her nutritional intake through a feeding tube. Review of a Care Plan for Resident #13 with a reference date of 6/4/25 revealed the following focus/goal/interventions: Focus: I have a history of dysphagia.deemed unsafe for any oral intake.Goal: I will remain NPO (nothing by mouth) to prevent choking. Interventions: Check patency (condition of being open) of g-tube (gastrostomy tube, feeding tube inserted through the abdomen directly into the stomach) prior to use. During an observation on 1/21/26 at 11:05am, a section of the wall approximately 4x5' in size, which Resident #13's bed was pushed against, was heavily soiled by dried drops of brown liquid. The dried liquid extended down the wall in streaks that were up to 2 feet long. Resident #13's linens rested against the soiled wall. Dried brown liquid was also noted on Resident #13's floor and feeding tube pole. During observations on 1/22/26 at 9:54am and 3:03pm, the soiled section of Resident #13's wall remained present with her bed pushed up against the wall. The feeding tube pole also remained soiled at the base with dried brown liquid. Resident #13's tube feeding formula was running and was noted (continued on next page)

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	235361	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be a light brown color. During an observation on 1/23/26 at 9:31am, Resident #13's wall and feeding tube pole remained soiled as previously described.

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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** Based on observation, interview, and record review, the facility failed to provide care and services to promote dignity for 1(Resident #13) of 1 resident reviewed for dignity resulting in a potential for feelings of decreased self-worth and embarrassment.Findings include:Resident #13Review of an admission Record revealed Resident #13 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: hemiplegia (severe or complete paralysis on one side of the body) and major depressive disorder (persistent depressed mood or loss of interest in activities causing significant impairment in daily life).Review of a Minimum Data Set (MDS) assessment for Resident #13 with a reference date of 1/2/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 00/15, which indicated the resident was severely cognitively impaired. Section GG revealed Resident #13 was dependent (helper does all the effort) for dressing her upper and lower body.Review of a Care Plan for Resident #13 with a reference date of 6/4/25 revealed the following focus/goal/interventions: Focus: I am dependent on staff for assistance with ADLs (activities of daily living), Goal: I will maintain my current level of functioning with assistance from staff. Interventions: (Resident #13) is dependent on staff for all dressing.During observations on 1/21/26 at 11:05am and 12:30pm, Resident #13 sat supported at a 45-degree angle in bed, awake, wearing a hospital gown that was gathered under her armpits, exposing her left breast and her incontinence brief. The resident's privacy curtain was not pulled around her bed, leaving her exposed to anyone who entered her room.During an observations on 1/22/26 at 9:54am and 3:03pm, Resident #13 sat supported in bed, awake with her hospital gown gathered under her armpits. The resident's abdomen, left breast, and incontinence brief were exposed. The resident's privacy curtain was not pulled around her.Review of a Dressing Task list revealed the only dressing assistance Resident #13 received on 1/22/26 took place at 9:03am. Resident #13 was observed wearing a hospital gown throughout that day.Review of a Behavior Documentation log revealed Resident #13 had no episodes of rejection of care in the last 14 days.In an interview on 1/22/26 at 9:40am, Family Member (FM) FF reported Resident #13 valued her modesty and would not want her torso exposed in view of others. FM FF also reported Resident #13 preferred to be dressed in her own clothes each day.In an interview on 1/23/26 at 9:31am, Registered Nurse (RN) E reported it was the expectation that staff assist Resident #13 with getting dressed in her own clothing each day because that was her preference.In an interview on 1/23/26 at 11:49am, Certified Nursing Assistant (CNA) X reported Resident #13 seemed to enjoy getting dressed each day and generally did not refuse assistance.In an interview on 1/23/26 at 10:51am, Director of Nursing (DON) B confirmed residents should be offered assistance with dressing in their own clothes each day and their dignity should be maintained by pulling privacy curtains around their beds if their private parts were exposed. DON B confirmed if a resident refused to get dressed, it should be documented on their dressing task list. Using the reasonable person concept, though Resident #13 could not verbalize feelings of embarrassment, it can be determined a reasonable person in the resident's position would have experienced embarrassment and a potential for feelings of decreased self-worth.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a transfer/discharge notice for 1 resident (Resident #49) of 2 residents reviewed for hospitalizations, resulting in the potential of residents and/or resident representatives being uninformed of the reason for transfer. Findings include: Resident #49 (R49)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R49 initially admitted to the facility on [DATE] with pertinent diagnoses including congestive heart failure (heart is too weak to pump blood to meet body's needs), heartburn and hypertension (high blood pressure). Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which indicated R49 was cognitively intact. R49 transferred to the hospital on 1/13/2026 after a fall with subdural hemorrhage (bleeding into the brain) and returned to the facility on 1/15/2026. During an observation on 1/21/2026 at 12:32 PM, R49 was resting in his room with his eyes closed in his wheelchair. He was too tired to speak with this surveyor.During an interview on 1/22/2026 at 4:13 PM, Registered Nurse (RN) P stated that he notified R49's guardian when he was transferred to the hospital. However, RN P couldn't remember filling out and sending a transfer/discharge notice with R49 or to his guardian when he went to the hospital. During another interview on 1/23/2026 at 9:20 AM, R49 stated that he remembered falling and being sent to the hospital. R15 couldn't remember RN P discussing the transfer/discharge notice.Review of R49's chart revealed that there was no transfer/discharge notice from 1/13/2026.During an interview on 1/23/2026 at 12:51 PM, Licensed Practical Nurse (LPN) N stated that he sends a transfer form with medications and other information when a resident is transferred to the hospital, but he hadn't heard of a transfer/discharge notice and hadn't been sending that with a resident transfer to the hospital. During an interview on 1/23/2026 at 11:41 AM, NHA A and Regional Clinical Nurse (RCN) stated that the facility had not been sending the transfer/discharge notice when a resident went to the hospital and they talked about implementing it. Review of the Discharge or Transfer Policy with an updated date of 1/28/2020 revealed .1. Transfer/discharge: Emergency.e. Provide Transfer Notice .to the resident and/or an immediate family member or legal representative. F. Document entire process in Nursing Progress Note.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan that reflected the minimum healthcare information necessary to properly care for a resident based on admission orders and physician orders including, indwelling foley catheter (tube inserted into the bladder to drain urine) and cardiac pacemaker (mechanical device implanted under the skin that regulates heart rate) for 1 resident (Resident #63) of 1 resident reviewed for baseline care planning, resulting in the potential for unmet care needs and residents not maintaining their highest practicable physical, mental, and psychosocial well-being.Findings include:Review of an admission Record revealed Resident #63 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic arial fibrillation (irregular and rapid heart rate), cardiac pacemaker, obstructive uropathy and urogenital implant (indwelling foley catheter). Review of Resident #63's Baseline Care Plan dated 1/14/26 @ 9:03 AM revealed, .C: Bowel and Bladder: Urinary Continence: Not Rated.Bowel and Bladder Appliances: None of the above (indwelling catheter was not selected). Catheter Care Planning: (No selections). There was no information related to cardiac pacemaker.Review of Resident #63's current Care Plan for indwelling foley catheter and cardiac pacemaker, revealed no information related to either appliance.Review of Resident #63's Physician Orders revealed, Maintain Foley catheter with 16 Fr 5cc balloon every shift.Start date 1/14/26 at 2:30 PM. There were 2 orders for Pacemaker that were queued on 1/14/26, but not active. Pacemaker (make) (model) (serial#) and Pacemaker check: to be completed via: (location/phone number).Review of Resident #63's Treatment Administration Record (TAR) revealed, Maintain Foley catheter with 16 Fr 5cc balloon every shift.Start date 1/14/26 at 2:30 PM. There were no treatment orders related to the cardiac pacemaker.Review of Resident #63's Nursing admission Assessment dated 1/14/26 indicated the resident had a diagnosis of chronic atrial fibrillation and his heart rate was irregular, but did not note that a pacemaker was in place. The assessment also indicated Resident #63 had a diagnosis of urinary obstruction and a foley catheter was in place.In an interview on 1/23/26 at 2:09 PM, Director of Nursing (DON) B reported that Resident #63 was admitted on [DATE] (9 days ago) with an indwelling foley catheter and had physician orders in place, but Resident #63's baseline care plan was incorrectly completed and indicated that the resident was incontinent and there was no catheter in place. DON B reported that the CNA (Certified Nursing Assistant) task's list included the foley catheter and therefore it showed up on the Kardex (CNA care guide) but did not pull through to the Care Plan. DON B reported that Resident #63 was admitted with a cardiac pacemaker but Resident #63's orders had not been activated because they were waiting to receive a model number for the pacemaker. DON B reported the facility received the model number via a copy of the pacemaker identification card but the copy was placed in a file to be scanned into the documents section in the resident record. DON B reported that Resident #63's baseline care plan did not indicate that he had a pacemaker and/or an irregular heart rate. DON B reported that it would be pertinent for staff to be aware of health condition and the pacemaker because Resident #63 should not get close to a microwave and to monitor heart rate to ensure pacemaker was functioning properly. DON B reported that going forward she would ensure that pacemaker orders were activated immediately upon admission.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain professional standards of care and provide adequate incontinence care in 1 resident (Resident #55) of 1 resident, reviewed for bowel and bladder incontinence, resulting in an increased risk for UTI (urinary tract infection) and the potential for skin breakdown.Findings include:Resident #55Review of an admission Record revealed Resident #55 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: constipation and need for assistance with personal care.Review of Resident #55's Care Plan revealed, .FOCUS: (Resident #55) requires extensive assistance with bed mobility.total assistance with oral hygiene, personal hygiene, toileting hygiene, and showering/bathing.FOCUS: .at increased risk for alterations in skin integrity r/t (related to) incontinence of bowel and bladder, impaired mobility. Date initiated: 12/16/16.Interventions: .Precautions for prevention of pressure ulcers will be implemented, such as good peri-care (cleaning the genital and buttock areas) and drying of (Resident #55's) skin, apply protective barrier cream.Date initiated: 9/8/18 .FOCUS: .incontinent of bowel and bladder. Date initiated: 10/12/16.Administer appropriate cleansing and peri-care after each incontinent episode. FOCUS: .at risk for UTIs (urinary tract infections) r/t incontinence of bowel and bladder, impaired mobility, and needs extensive total assistance with care. Date initiated: 9/10/24.FOCUS: .alteration in elimination due to bowel and bladder incontinence. Date initiated: 3/10/25. Interventions: .Provide incontinence care after incontinence episode PRN (as needed). Date initiated: 3/10/25 .Review of Resident #55's Treatment Administration Order (TAR) revealed, Moisture Barrier Ointment: apply to peri-areas and buttocks topically every shift for skin protection. May keep at bedside. (CNA (certified nursing assistant) may apply). The record indicated that staff were applying the cream three times a day.During an observation on 01/21/2026 at 1:19 PM in Resident #55's room, CNA AA and CNA L prepared to transfer the resident into bed and perform incontinence care. CNA L reported that the resident had been up in her chair since before 7:00 AM (>6 hours). There was a strong urine smell when the resident was transferred into the bed, the chair was visibly wet where she had been seated, and her pants were visibly wet in the buttock area. Staff removed Resident #55's incontinence brief and it was observed saturated and heavy with dark yellow-brown urine. CNA AA performed incontinence care and CNA L helped with repositioning. CNA AA used disposable wipes to clean down the groin folds on the front of Resident #55 but did not clean the genital folds or attempt to clean between the resident's legs. CNA AA cleaned the resident's buttocks and there was BM noted between her buttocks and on the wipe. CNA AA changed her gloves but did not perform hand hygiene. The staff did not apply a barrier cream to Resident #55's peri-area following the incontinence episode.In an interview on 01/21/2026 at 1:36 PM, CNA L reported that it was normal for Resident #55's urine to smell strong and she did not remember having to collect a urine specimen for the resident recently. In an interview on 1/22/26 at 4:38 PM, CNA Y reported that she had Resident #55 on her assignment that day on first shift but had not tried to do care for Resident #55 because third shift staff had gotten Resident #55 up into her chair that morning and the resident's routine was to stay up all day. CNA Y reported that the resident would get mad if you tried to perform incontinence care between meals and only allowed incontinence care a couple times a day. CNA Y reported that Resident #55 needed very thorough incontinence care when it was done and thick barrier cream applied to keep her skin from breaking down due to her being in a wet brief all day. During an observation on 01/22/2026 at 2:33 PM in Resident #55's room CNA J and CNA W were preparing to transfer the resident into bed and provide incontinence care. Observed incontinence care for Resident #55 by CNA J. Resident #55's incontinence brief was observed saturated and heavy with urine. There was a strong urine odor when the resident was transferred into bed. CNA J performed the incontinence care using disposable wipes to clean the resident's front groin folds and then the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	buttocks; observed BM (bowel movement) between the buttocks and on the disposable wipes during incontinence care. Staff did not clean the resident's genital folds or between the resident's legs and did not apply barrier cream following incontinence care. CNA J did not change gloves or perform hand hygiene; with the same gloves CNA J opened the resident's nightstand drawer, used the bed controls and handed Resident #55 her call light. CNA J touched clean surfaces with contaminated gloves. In an interview on 1/22/26 at 2:50 PM, CNA J was unsure of the facility expectations regarding glove use and hand hygiene related to incontinence care. CNA J reported that he was not sure why Resident #55 was not laid down after meals that day, but that was the expectation for residents with incontinence. CNA J reported that Resident #55 does not have barrier cream and does not need it because she does not have any skin breakdown.In an interview on 01/23/2026 at 10:33 AM, CNA W reported that Resident #55 was a very heavy wetter and was usually out of bed before first shift starts.In an interview on 1/23/26 at 11:32 AM, Director of Nursing (DON) B reported that incontinence care should include thoroughly cleaning the folds of the female genitals, gloves should be changed after contact with BM, and barrier cream should be used with every incontinence episode.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate medical records for 1 resident (Resident #55) of 14 residents reviewed for complete and accurate medical record documentation, resulting in the potential for staff and providers mismanaging care for residents. Findings include:Resident #55Review of an admission Record revealed Resident #55 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: depression, anxiety and dementia.Review of Resident #55's Care Plan revealed, FOCUS: .history of anxiety and may exhibit signs or symptoms as evidenced by episodes of agitation, restlessness, tearfulness, and worried facial expressions. Date initiated: 3/3/25 FOCUS: history of depression and may exhibit signs and symptoms of depression as evidenced by episodes of crying, fearfulness negative statements, and/or having a sad, pained, or worried facial expression. Date initiated: 3/3/25 . Review of Resident #55's Physician Note dated 1/12/26 revealed, .Chief Complaint: Weight loss .Current Medications: .Lexapro (antidepressant) oral tablet 5 mg .Plan: .Ensure proper administration of prescribed medication .medications were reviewed and reconciled . Review of Resident #55's Physician Orders revealed, the orders did not include Lexapro. Review of Resident #55's Discontinued Physician Orders revealed, Lexapro oral tablet 5 mg .discontinued, end date: 8/19/2024 . In an interview on 01/22/2026 at 1:24 PM, Social Worker (SW) G reported that Resident #55 was not taking any medications for depression and that Lexapro had been discontinued through GDR (gradual dose reduction) in August of 2024. After reviewing the physician notes SW G agreed that the information related to Lexapro was not correct; the notes did not include documentation of the Lexapro GDR. Previous notes were reviewed back through August 2024 and all were found with the same inaccurate information related to Lexapro. SW G reported that Resident #55' GDR was a recommendation from the pharmacist in collaboration with facility interdisciplinary team members and Medical Director (MD) DD. SW G reported that Resident #55's GDR of Lexapro was successful and the resident was doing well since then. In an interview on 1/22/26 at 1:30 PM, Medical Director (MD) DD reported that he agreed that his physician notes did not accurately reflect Resident #55's current medications. MD DD reported that during all resident visits he reviewed the active medication list in the electronic health record, but he was not sure why that list was not accurately transcribed into the visit note. MD DD added that he did not normally include GDR information related to depression medications, as he expected the behavioral health providers to document their findings. Review of the most recent Psychiatry Progress Note dated 11/4/24 revealed, .ongoing management of psychotropic medications and neuropsychiatric conditions .Diagnosis, A/P (assessment and plan): Major depressive disorder, recurrent, moderate. Appears stable currently. 1. Continue Lexapro 5mg daily. 2. Continue to monitor and document any clinically significant changes in mood/behaviors. Generalized anxiety disorder: Moderately stable. 1. Continue Lexapro 5 mg daily . In an interview on 01/23/2026 at 12:42 PM, Medical Records (MR) S reported that she was not sure how MD DD's visit notes became part of the medical record, but that she did not scan them into the electronic health record and that she was not responsible for the accuracy of the notes. In an interview on 01/23/2026 at 2:09 PM, Director of Nursing (DON) B reported that MD DD's visit notes were uploaded to the electronic medical record by MD DD and the notes had not been reviewed for accuracy.