STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235370	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of St. Clair	4220 S. Hospital Drive East China, MI 48054

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly dispose of waste and maintain dumpster area to mitigate the presence of pests, potentially affecting all residents in the facility. Findings include:On 12/8/25 at approximately 7:50 AM, the facility's exterior trash refuse area was observed with Food Service Manager D. The dumpsters were observed to be overflowing with stacked up trash bags. The bags were piled up beyond the top edge of the containers, to the point where the lids could not be closed. When queried at that time, Food Service Manager D stated that the containers were usually overflowing after the weekend. When queried regarding how often the containers were emptied, Food Service Manager D stated, I believe once a week. According to the 2022 FDA Food Code section 5-501.110 Storing Refuse, Recyclables, and Returnables, REFUSE, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.According to the 2022 FDA Food Code section 5-501.113 Covering Receptacles, Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: .(2) After they are filled; and (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT.

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program by eliminating harborage conditions. This deficient practice had the potential to affect all residents, staff and visitors. Findings include: On 12/8/25 at 7:35 AM, the facility's dish machine was observed. Underneath the soiled side drain board, there was a build-up of sludge on the floor tiles, and the flooring was damp. There was a cup and a small bowl which had accumulated on the floor along the back wall. There were numerous gnats observed on the pipes and the back wall under the soiled drain board. When queried at that time, Food Service Manager D confirmed the presence of the gnats and stated that the flooring was in need of a good cleaning. According to the 2022 FDA Food Code section 6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A)Routinely inspecting incoming shipments of FOOD and supplies;(B)Routinely inspecting the PREMISES for evidence of pests;(C)Using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12,7-206.12, and 7-206.13; and (D)Eliminating harborage conditions.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake number 2660263.Based on observation, interview and record review, the facility failed to ensure sufficient staff were available to answer call lights and to provide timely resident care for four residents (R19, R20, R23, R131) and six group residents in a census of 120. Findings include: On 12/08/2025 at 8:47 AM, Certified Nursing Assistant (CNA) A was asked about staffing levels and reported staffing is horrible and reported they had twenty patients to care for over the weekend due to call ins and med techs not helping with patients on the floor. On 12/08/2025 at 9:04 AM, R23 reported that on average there is not enough staff to take care of the residents three times a week. R23 feels this happens most often on the midnight shift. R23 reported wait times up to 45 minutes for call lights to be answered. R23 further reported this was due to the aides working shorthanded. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented an admission into the facility on [DATE], intact cognition (15/15 Brief Interview for Mental Status score) and the need for substantial/maximal assistance with bathing, dressing and personal hygiene. Partial/Moderate assistance was needed for toileting. On 12/08/2025 at 11:31 AM, R131 reported the facility does not have enough employees to take care of patients and had been currently waiting for 15 minutes for assistance and has waited up to an hour. On 12/10/2025 at 8:50 AM, R20 reported multiple call ins reported by staff and the facility does not have enough additional staff to fill in. R20 reported this was told to them by staff when R20 complained about the wait times. R20 further commented the facility has had four Administrators in the last year and no one holds the staff accountable when they call in. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented an admission into the facility on [DATE], intact cognition (14/15 Brief Interview for Mental Status score) and R20 was dependent on staff for bathing, dressing and personal hygiene. A review of the resident council meeting minutes documentation revealed call light response concerns expressed by the group during the months of August and September 2025. On 12/9/25 at 1:15 PM, a resident council meeting with eight group members were asked about excessive wait times for staff when they activated their call light. Six of the group members, confirmed wait times could be up to an hour. On 12/9/25 at 3:22 PM, in the hallway of the 300 unit, R19 indicated they had been waiting close to twenty minutes for their call light to be answered. Observed was made of multiple staff members walking back and forth passing R19's room and did not respond to their call light. An additional observation of the call light screen located behind the nurse's station on the unit revealed R19's call light had been activated at 3:05 pm and staff responded at 3:30 PM, On 12/10/25 at 4:27 PM, the Administrator (NHA) was interviewed regarding their expectation for call light response time by staff. The NHA indicated within thirty minutes was their expectation.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide palatable food items per the resident's preference for four residents (R20, R55, R69 and R80) and eight resident council group members from a census of 120. Findings include: On 12/8/25 at 9:17 AM, R69 was interviewed about the food served to them at the facility and indicated the food was cold and didn't taste good. A review of R69's most recent minimum data set assessment (MDS) dated [DATE] revealed R69 had an intact cognition. On 12/9/25 at 1:15 PM, a resident council meeting was conducted between the surveyor and eight group members. All eight group members expressed concerns regarding the temperature and taste of the food served to them A review of the resident council meeting minute documentation revealed palatable food and temperature concerns expressed by the group during the months of July, October, November, and December 2025. A review of resident food committee meeting minute documentation revealed cold food concerns expressed by the group during the months of July, August, and September 2025. . R20 On 12/10/2025 at 8:50 AM, R20 reported concerns with the food service at the facility. R20 reported the facility did not order enough food as when they call for a substitute from the alternate menu it is not available and feels that corporate should not have control over the menu items served to the residents. R20 stated, If it is not on the tray, you are not going to get it. R 20 also reported they do not receive chips or bananas as often as the used to and they are lucky to receive any meat items such as sausage or bacon for breakfast. R20 reported they had been at the facility four years and the used to be able to get bacon and real eggs every morning. R20 further noted any complaints have not led to any real changes being made. R20 did not appear to have eaten the eggs on their breakfast plate and asked the aide to take the tray out. The Minimum Data Set (MDS) dated [DATE] documented intact cognition and the need for set up for eating. R55 On 12/08/2025 at 11:19 AM, R55 reported the food is served cold in both the dining room and when they eat in their room. R80 On 12/08/2025 at 11:29 AM, R80 reported the food is cold for most meals and they eat in the dining room. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/2025 at 4:27 PM, the Nursing Home Administrator (NHA) was asked about the food delivery process. The NHA explained the facility expectations is for the food to be delivered to the residents in a timely manner to maintain the temperature.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor the right to share a room with their spouse and failed to provide written notice, including reason for the change, prior to a room change for one sampled resident (R19) of nine reviewed for resident rights. Findings include: On 12/08/2025 at 9:36 AM, R19 reported that they were upset because the facility changed their room, which separated them from their spouse. During the interview R19 was observed to cry and be visibly upset due to the emotions they were feeling. R19 stated, They never should have divided us. R19 reported they had been married for three months and only had about three weeks together in the same room. R19 further explained the facility gave them about a 10 minute notice before the room change occurred. On 12/10/2025 at 2:44 PM, Social Services C was asked about the room change with R19 and reported they were not involved with the room change. Social Services C further explained, they talked to the couple on the day after to check on the couple. Social Services C was asked about the conversation and stated R19, and their spouse they were both upset. On 12/10/2025 at 4:47 PM, the Nursing Home Administrator (NHA) was asked about the room change and explained, the facility accepted a new resident we had to take (admit) and R19's room was the only option. The NHA acknowledged it was a last-minute decision for R19 to be moved away from their spouse. A review of R19's medical record census section revealed a room change on 11/28/25. Further review revealed there was no documentation regarding the notification of the room change to R19's guardian or to the resident. Further review of R19's medical record revealed, R19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Right femur fracture.A review of the facility's policy titled Change of Room or Roommate dated 10/30/2023, revealed, Policy: It is the policy of this facility to conduct room changes or roommate assignments when considered to be necessary by the facility and/or when requested by the resident or resident representative. Policy Explanation and Compliance Guidelines: 2. Reasons for a change in room or roommate could include but are not limited to: a. Incompatibility of residents in a shared room. 3. Requests for changes in room or roommate should be communicated to the Social Service Designee. 4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such asresidents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will be provided, in a language and manner the resident and representative understand and will include the reason(s) why the move or change is required. 6. The social service staff can assist the resident to adjust to the new room or roommate by: a. Informing the resident and family as soon as possible of the room or roommate change. b. Involving the resident in the decision and selection of a room or roommate when possible. c. Allowing the resident to ask questions about the move. d. Showing the resident where the room is located. e. Introducing the resident to his/her new roommate and sharing information about the new roommate. 7. The Social Service designee or Licensed Nurse should inform the resident's sponsor/family in advance of a change in the resident's room or roommate. 8. A resident has the right to refuse a transfer to another room within the facility, if the purpose of the transfer is torelocate a resident from the Medicare section of the facility to a non-Medicare section of the facility solely for financial or change in payer status reasons .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to complaint number 2686759.Based on interviews/record review, the facility failed to protect one resident's (R106) right to be free from physical abuse by another resident (R104) of two residents reviewed for abuse. Findings include: A review of an incident and accident report dated 11/28/25 and involving R104 and R106 indicated the following, R104 was having a behavioral episode in the hallway, as another resident (R106) was walking down the hallway past them. R104 approached R106 and placed their hands around R106's neck and started squeezing. Licensed Practical Nurse (LPN) H intervened and R104 let go of R106's neck and pushed R106 causing them to fall on their knees and then on their buttocks. R104 was redirected away from the other residents. R106 stated, [R104] was choking me, almost killed me. Vital signs and skin assessment was completed on R106. Observation made of abrasion on R106's front of right knee and redness to elbow. R104A record review of social work progress notes in R104's electronic medical record (EMR) documented the following:-On 6/5/24[25] 4:23 PM, Social Work (SW) came down to [R104's] hall. [R104] and another resident were arguing with the nurse regarding one another. [R104] turned away from the nurse and stated, 'multiple swear words and die, die, die.' [R104] went to their room and was mumbling to themselves. [R104] exited their room and walked into another resident's room. SW escorted [R104] to dining room to eat. SW to meet with Interdisciplinary team (IDT) to discuss [R104] and interventions.-On 11/5/25 1:48 PM, SW was called down to resident's room due to resident slamming doors and stating, die, die, die. SW escorted resident to lunch. -On 11/7/25 2:50 PM, Resident was continuously slamming doors and stating, 'die, die, die, kill myself, happy, die, die, die. Resident was slamming furniture in their room and broke a panel on the dresser drawer. Other residents were verbally and visibly disturbed with resident's behavior. Resident was petitioned to [Hospital] for mental health evaluation and transported by emergency medical services (EMS). A review of R104's Behavior care plan indicated R104 had behaviors as evidenced by physical aggression towards residents. R104's goal was to display no evidence of behavioral problems through the next review period with a target date of 3/10/2026. Intervention indicated to keep the resident safe during episodes of behaviors. Further review of R104's EMR revealed R104 was originally admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and Chronic obstructive pulmonary disease (COPD). R104's most recent minimum data set assessment (MDS) dated [DATE] revealed R104 had a severely impaired cognition. R104 was transferred to the hospital on [DATE] for a metal health evaluation and returned to the facility on [DATE]. R106A review of R106's EMR revealed R106 was originally admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder and Dementia. R106's most recent MDS assessment dated [DATE] revealed R106 had a severely impaired cognition. On 12/8/25 at 3:00 PM: R106 was interviewed in their room regarding the incident which occurred on 11/28/25 involving them and R104. R106 indicated they had no recollection of the incident. On 12/8/25 at 3:10 PM, Certified Nurse Assistant (CNA) L was interviewed about the incident which occurred between R104 and R106. CNA H indicated they were summoned to the hallway by LPN H for assistance and observed R106 on the ground with red marks on their neck and an abrasion on their knee. CNA L and LPN H assessed the resident and CNA L assisted them to their room. CNA L was asked about R104's behaviors and confirmed at times R104 would become agitated and slam doors on the unit. On 12/10/25 at 1:45 PM, LPN H was interviewed about the incident which occurred between R104 and R106. LPN H confirmed R104 was agitated and grabbed R106 by the neck as they were walking by and push them down to the ground causing red marks on their neck and an abrasion on their right knee. LPN H indicated R104's behavior had been escalating and becoming increasingly aggressive over the past two or three months to which they notified the unit nurse manager, social services, and the Director of Nursing (DON). Nurse (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H was asked about any new interventions that were put in place in response to R106's escalating behaviors and indicated they were unsure about any new behavioral interventions. On 2/10/25 at 2:28 PM, R104 was interviewed regarding the incident which occurred between themself and R106. R104 indicated they had no recollection of the incident. At 3:31 PM, the Director of Nursing (DON) was interviewed about the incident between R104 and R106. The DON indicated R104's behavior had been escalating for the past two or three months and when staff noticed R104 escalating, staff could have taken them to a quiet area to calm down. A review of a facility policy titled Abuse .Date Reviewed/Revised: 01/10/2024 revealed the following, Policy: It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .Definition: Abuse means the willful infliction of injury .with resulting physical harm .which can include .certain resident to resident altercations. Willful means the individual must have acted deliberately .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a PASARR (Preadmission Screening Annual Resident Review for mental health needs) was completed timely for two residents (R11, R75) of three reviewed for PASARR completion. Findings include: R11 A review of the facility records for R11 revealed R11 was admitted into the facility on [DATE]. Diagnoses included Schizoaffective Disorder, Stroke and High Blood Pressure. R11 has continued to reside at the facility. The PASARR form dated 09/24/25 documented it as a hospital exempted discharge which indicated R11 was expected to remain at the facility less than thirty days. An additional level one PASARR was required after 30 days. Further record review revealed no additional PASARR had been entered into the medical record. On 12/10/25 at 1:12 PM and 4:15 PM the additional level one PASARR was requested. At 4:35 PM the facility reported the additional level one PASARR had not been completed. R75 A review of R75's medical record revealed they were admitted into the facility on 7/22/25 with diagnoses which included Anxiety Disorder, Bipolar Disorder, current episode mixed, Major Depressive Disorder and Diabetes. Further review revealed the resident was cognitively intact and required 2-person assist for activities of daily living. Further review of the medical record revealed a Level 1 Pre-admission Screening form dated 7/16/25 which was completed by the hospital nurse that referred the resident to the facility. Further review of the screening form revealed screening criteria which noted the person had a current mental illness, received treatment for the mental illness, and had routinely received one or more prescribed antipsychotic or antidepressants in the last 14 days. The document further explained the person had moderate recurrent major depression and was prescribed Wellbutrin (anti-depressant) 150mg (milligrams), and Buspar (anti-anxiety) 30mg. On 12/10/25 at 1:58 PM, R75's PASARR completed by the facility was requested however, the form provided was the form completed by the referring hospital and not the facility. On 12/10/25 at 2:15 PM, Social Worker C was interviewed regarding the completion of PASARRs and explained that the corporate social worker was completing them, and they were in the process of changing the process for how the forms were being completed. A review of the facility's Resident Assessment-Coordination with PASARR Program (Michigan) policy revealed the following, .5. If a resident who was not screened due to an exception above and remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level 1 Screening process and refer any resident who as or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2660263.Based on observation, interview, and record review, the facility failed to provide timely Activities of Daily Living (ADLs) for three sampled residents (R19, R55, and R80) of six reviewed for ADLs. Findings include: R19On 12/08/2025 at 9:36 AM, R19's bed was observed with a large wet area in the middle of the bed. R19 reported they were not changed during the midnight shift. R19 reported they have to wait a long time for assistance at times. Further review of R19's medical record revealed, R19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Right femur fracture. A review of R19's Minimum Data Set (MDS) assessment noted R19 with moderately impaired cognition and required assistance with activities of daily living. R55On 12/08/2025 at 11:19 AM, R55 reported that one day they waited over two hours to be cleaned after having a soiled brief. R55 also reported they had been told by staff they were too busy to provide their scheduled showers and then have documented R55 as refusing a shower when that was not the case. A review of R55's shower documentation noted refusals for showers, without a progress note indicating the reason or follow up by a nurse.A review of R55's medical record noted, R55 was admitted to the facility on [DATE] with diagnosis of Progressive Neurological Conditions. A review of R55's MDS assessment noted R55 with intact cognition and required assistance with activities of daily living. R80On 12/08/2025 at 11:29 AM, R80 reported they often wait a long time for their call light to be answered, and they don't always receive their showers as scheduled. R80 expressed that the call light wait time has been awful since the facility has switched to the pager system. A review of R80's medical record noted, R80 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Chronic Obstructive Pulmonary disease, R80 was noted to have an intact cognition, and required assistance with activities of daily living. On 12/08/25 at 11:35 AM, Certified Nursing Assistant (CNA K) was asked about their ability to complete care for all their residents. CNA K gave a nonverbal look/gesture as if they were not able to complete their work in a timely manner. CNA K did not offer any other information. On 12/10/2025 at 4:27 PM, the Nursing Home Administrator (NHA) was asked about the call lights and made aware of the above concerns. The NHA reported that call lights and completing ADLs are being monitored on an ongoing basis.A review of the facility's policy titled, Call lights: Accessibility and Timely Response dated 12/28/2023, revealed Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines:. 7. Any staff member who sees or hears an activated call light is responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to administer pain medications as ordered for one resident (R63) of one resident reviewed for pain management. Findings include: On 12/08/2025 at 8:12 AM, R63 was observed in their room and asked about their care in the facility. They explained they had been dealing with pain and hadn't received their prescribed Oxycodone (narcotic pain medication) last night as they were told it was out of stock. R63 further explained they were provided with Tylenol but admits that it doesn't provide relief the way the Oxycodone does. A review of R63's medical record revealed they were admitted into the facility on 8/29/25 with diagnoses which included Chronic Pain Syndrome, Heart Failure, and Diabetes. Further review revealed the resident was cognitively intact and required one-person assist for activities of daily living. A review of R63's care plan revealed the following, Focus: .related to back pain, UTI (urinary tract infection). Date Initiated: 11/28/2025 .Interventions: Administer medications per orders and observe for side effects and effectiveness .Date Initiated: 11/28/2025.Further review revealed the following active physician's order dated 11/28/25, Oxycodone HCl Oral Capsule 5 MG (milligrams, Oxycodone HCl). Give 1 capsule by mouth every 4 hours as needed for pain. Further review revealed the medication was placed on order. A review of R63's December Medication Administration Record (MAR) revealed the resident received the prescribed medication on 12/7/25 at 12:57pm for a pain level of 10. On 12/09/2025 at 9:14 AM, Licensed Practical Nurse (LPN) B was observed in conversation with R63. R63 asked about cream for their chest and the nurse reported it was not available in the medication cart. R63 then asked for their oxycodone pain medication for 10/10 pain affecting their back and legs. LPN B looked at the electronic medical record and reported the pain medication was on order. LPN B asked if the medication was new and R63 replied it was not. LPN B offered acetaminophen, and R63 indicated it would have to do. LPN B gave R63 acetaminophen and applied a pain patch to the lower back. A review of the facility's back-up supply medications revealed the facility had R63's oxycodone medication available.On 12/10/2025 at 3:45 PM, the Director of Nursing (DON) was asked about R63's medication not being provided when it was available in the facility's back up and explained she would get back with surveyor as there appeared to be a discrepancy with how the prescription was written.On 12/10/25 at 5:40 PM, the DON explained after researching and speaking to the nurse practitioner, they figured out what occurred regarding the medication.A review of the facility's Medication Administration policy did not address pain management or obtaining medications available from the facility's back-up supply.

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	235370	A. Building B. Wing	12/10/2025

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Medilodge of St. Clair	4220 S. Hospital Drive East China, MI 48054

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medications were available for two residents (R8 and R132) of three reviewed for medications. Findings include: R132 On 12/08/2025 at 10:51 AM, R132 reported missing doses of their medication for a number of days when they first arrived at the facility. R132 They screwed up my meds. R132 reported they were supposed to get eye drops and didn't get them until about 12/7/25. R132 also reported there was a delay with getting their antibiotic medication. A review of R132's medical record noted, Progress note: 11/28/2025 18:08 (6:08 PM) Nursing Evaluation Summary. Res arrived via EMS (Emergency Medical Services) from [local] Hospital approx. 1445 (2:45 PM) with daughter. A review of R132's Medication Administration Record (MAR) for the month of November 2025 noted, Cefazolin Sodium Intravenous Solution Reconstituted 2 GM (gram) (Cefazolin Sodium). Use 2 gram intravenously three times a day for MSSA (Methicillin-Susceptible Staphylococcus aureus) Bacteremia for 57 Administrations until finished. start date: 11/28/25. Scheduled times 0600 (6:00 AM), 1400 (2:00 PM) 2200 (10:00 PM). There was no documentation noted on the 28th (2200), 29th at (0600 and 1400) to indicate the medication was administered. Latanoprost Ophthalmic Solution 0.005 % (Latanoprost) Instill 1 drop in both eyes at bedtime related to Glaucoma -Start Date: 11/28/2025. There was a code of 'nine documented on 11/29/25, which indicated to see progress note. A review of the progress note revealed the medication was unavailable. Continued review of R132's November MAR revealed, there were 18 scheduled medications that were not documented as administered. Further review of R132's medical record noted, R132 was admitted to the facility on [DATE] with a diagnosis of Nonrheumatic aortic (valve) stenosis. A review of R132's Minimum Data Set (MDS) assessment noted R132 with an intact cognition and required assistance with activities of daily living. On 12/09/2025 at 3:54 PM, Nurse Unit Manager J was asked about R132 medications and reported that R132's medications were not delivered timely. A review of the pharmacy delivery manifest noted, R132 medications were delivered on 11/29/25 at 11:06 PM. Unit Manager J explained the medication would have usually been delivered at the 5:00 AM delivery. A review of Physician Assistant (PA) F note dated 11/29/25 documented, .(R8) was admitted to the hospital on [DATE] for urosepsis, altered mental status, abdominal pain, and dysuria . Regarding (R8's) pain control, (R8) is currently prescribed Lyrica (pregabalin) 200 (milligrams) mg every 12 hours for polyneuropathy. Patient has a history of lumbar spinal stenosis (stiffness) and diabetes, which are both likely contributing to (R8's) symptoms. (R8) is taking Xtampza (oxycodone opioid) ER (extended release) 9 mg up to twice daily for chronic severe pain and needs a refill. For less severe pain (R8) is prescribed Norco (opioid hydrocodone) 10/325 mg . A review of Physician E note dated 12/02/2025 at 10:02 AM, documented, (R8) was seen by request (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the nurse. The patient was out of pain medication yesterday and I was not aware. Medications were sent immediately on request. The patient is still requesting to be sent out (to the hospital). The patient states the pain is in the suprapubic catheter (tube placed into the bladder to drain urine). The patient also has a left leg amputation and wounds to (their) right leg. When I walked into the facility the patient was resting comfortably. The patient has a history of diabetes. The patient has a left 5th nail bed avulsion (torn off). The patient stated to the nurse (R8) does not want wound care . Patient called EMS (emergency medical service) themself and is being transferred out . A review of the nursing progress note dated 12/02/2025 at 10:07 AM revealed, Resident transferred to (hospital) via EMS for uncontrolled pain. Non-pharmacological interventions were offered, but resident refused and stated that (they) wanted to go out to the hospital so (their) pain can be managed quickly . On 12/09/2025 at 12:19 PM and at 12:36 PM, Registered Nurse (RN) G reported R8 had chronic pain with an average pain rating of 6-8 out of ten. RN G reported there had been delays in getting pain medications for R8 and the Xtampza was not kept in the back up for medications. It was noted that no PRN (as needed pain medications) were given the day R8 went out to the hospital. RN G reported that if R8 did not have the Xtampza or could not take all the pain medications then would refuse the Norco and just want to go to hospital. A review of the facility records for R8 revealed R8 was at the facility from 10/28/25 to 12/02/25. Diagnoses included Arthritis, Left leg above the knee amputation, and Depression. The Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition with a 14/15 Brief Interview for Mental Status score and severe pain frequently in the last five days. The vitals documented pain levels of zero to nine in the five days prior to discharge. A review of the medication administration records (MAR) for November and December 2025 revealed the Xtampza/Oxycodone was not given on 11/30, 12/01 and 12/02. The PRN hydrocodone/acetaminophen was also not given on 11/30, 12/1 and 12/2. A review of the medication orders revealed, hydrocodone-acetaminophen 10-325 mg tablet Give 1 tablet by mouth every 6 hours as needed for moderate-severe pain; methocarbamol (muscle relaxer) 500 mg tablet Give 1 tablet by mouth four times a day for Pain Give 0.5 tablet by mouth four times a day for pain; Xtampza(Oxycodone) ER Oral Capsule ER 12 Hour Abuse-Deterrent 9 MG (Oxycodone), every twelve hours, and Lyrica 200 mg Take one capsule by mouth two times per day. A review of the November 2025 Control Substance Records for the Xtampza revealed the last dose was given on 11/29/25 at 8 AM. On 12/10/25 at 1:00 PM the Director of Nursing (DON) reported medication should be ordered timely and administered as ordered. The DON further noted PA may not have been aware the oxycodone was taken twice a day and only ordered four pills. A review of the facility policy titled, Ordering and Receiving Non-Controlled Medications revised June 2024 revealed, Policy: Medications and related products are received from the pharmacy on a timely basis . A review of the facility policy titled, Controlled Substance Prescriptions revised August 2020 revealed: .Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe controlled substances. A chart order is not equivalent to a prescription for controlled medications. Therefore, the prescriber issuing the chart order must also provide the pharmacy with a valid prescription to ensure delivery of medication. The written prescription may be faxed to the pharmacy for long-term care facility residents .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to properly store medications for one resident (R6) of one reviewed for medication storage, ensure expired medications were discarded when opened, and inhalers were labeled with a resident identifier and/or an opened date in one of four medication carts. Findings include: R6 On 12/08/2025 at 7:32 AM, during a tour of the Dementia unit, R6 was observed in bed asleep. A medication cup containing two pills was observed on the resident's nightstand. On 12/08/2025 at 7:39 AM, an unidentified nurse was asked to observe the medications at R6's bedside and explained they had not begun to pass medications on the day shift and further explained they are not aware of how long those medications had been on the nightstand. A review of R6's medical record revealed they were admitted into the facility on 8/27/25 with diagnoses of Alcohol Dependence with Alcohol-Induced Persisting Dementia, Metabolic Encephalopathy, and Major Depressive Disorder. Further review revealed the resident was moderately cognitively impaired and required one-person assist with activities of daily living. Further review of R6's medical record did not reveal a self-administration of medications assessment. On 12/10/2025 at 3:25 PM, the Director of Nursing (DON) was asked about the observation made of R6's medications left at the bedside and explained that is not the practice of the facility, and they should not have been left there. On 12/09/2025 at 9:48 AM, the D wing medication cart was reviewed with Licensed Practical Nurse (LPN) B. A Humalog insulin pen for R67 had a date opened of 11/06/25 and had not been discarded; A Fluticasone Salmeterol Advair 250-50 mcg (microgram) inhaler for R66 was not dated when opened on the actual inhaler; and a Fluticasone-Salmeterol 250-50 mcg inhaler for R42 was not labeled with a resident identifier on the actual inhaler. On 12/10/25 at 1:00 PM, the Director of Nursing (DON) reported the expired insulin should have been discarded. A review of the facility policy titled, Medication Storage revised 01/20/24 revealed, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations . A review of the manufacturer's insert for the fluticasone/salmeterol inhaler revealed, How should I store (fluticasone/salmeterol)?Keep in a dry place away from heat and sunlight. Store {fluticasone/salmeterol) in the unopened foil pouch and only open when ready for use. Safely throw away (fluticasone/salmeterol) in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first. A review of the manufacturer's insert for the Humalog insulin pen revealed, .In-use pen: Store the pen (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	you are currently using at room temperature Keep away from heat and light. Throw away the Humalog pen you are using after 28 days, even if it still has insulin left in it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure hand hygiene and medical device cleaning was completed during medication pass for one resident (R89) of four residents observed during observed. Findings include: On 12/10/2025 8:23 AM, Licensed Practical Nurse (LPN) I was observed during a medication pass for R89. LPN I was observed to remove five oral medications, a glucometer, a lancet, glucose (blood sugar) test strip and an alcohol pad from the medication cart. LPN I reported they wanted to recheck R89's blood sugar. The medications were dispensed into a small plastic cup. LPN I brought the items into the resident's room and donned gloves. The medication cup was handed to R89 by LPN I. The lancet was used to prick a finger on the left hand of R89 to get the blood sample for the meter onto the glucose test strip. LPN I doffed their gloves and returned to the medication cart. The glucometer was returned to the medication cart. LPN I prepared an insulin injection for R89 using an insulin pen. A needle was applied to the pen and the amount dialed onto the pen. LPN I entered R89's room donned gloves and administered the insulin into the back of R89's left arm. LPN I doffed their gloves and exited the room. LPN I then took the thermometer and a pulse ox device (to check oxygen level) from the cart and checked the temperature on the left temple of R89 and the pulse ox on a digit of the left hand. LPN I exited the room and placed the two devices on top of the cart. The glucometer, thermometer and pulse ox were not wiped down after use. No hand hygiene was observed to have been performed during the observation. LPN I was able to remove a bottle of hand sanitizer from their pocket. It was not accessed during the medication pass observation. A wall mounted dispenser for hand sanitizer a couple rooms down from R89's was tested and did dispense sanitizer when a hand was placed below the sensor. LPN I reported there were no sanitizing cloths for the devices on the medication cart, and none were observed.On 12/10/25 at 1:00 PM, the Director of Nursing (DON) reported the expectation was for the nurse to complete hand hygiene before and after each incidence of care. A review of the policy titled, Medication Administration revised 01/17/23, revealed, .Wash hands prior to administering medication per facility protocol and product . Observe consumption of medication . Wash hands using facility protocol and policy .'