STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235373	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Lodge Trinity Health	18525 Woodland Ridge Drive Spring Lake, MI 49456

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to assess one resident (R66) for self-administration of medication and failed to track and record medication use. Findings: Review of the Electronic Medical Record (EMR) reflected R66 was admitted to the facility 5/1/25 with pertinent diagnoses that included Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease (COPD), and Emphysema. On 6/11/25 at 9:43 AM, R66 was observed in a recliner chair receiving supplemental oxygen through a nasal cannula. Also observed were a nebulizer machine, a device like a Continuous Positive Airway Pressure (CPAP) machine and an Albuterol multidose inhaler on the over-the-bed table next to the Resident. On 6/12/25 at 2:34 PM an observation and interview were conducted with R66 in his room. The Albuterol multi-use inhaler was again observed on the over the bed table next to R66. R66 reported he used the inhaler sometimes a couple of times a day. R66 reported staff had not asked him if he had used it or how often. R66 indicated staff never asked him anything about the inhaler. Review of the EMR Doctor's Orders for R66 reflected an order for Ventolin HFA Inhalation Aerosol Solution 90 micrograms (mcg) (Albuterol Sulfate) 2 puff inhale orally every 6 hours as needed for COPD/wheezing. May leave at bedside with a start date of 5/5/25. The policy provided by the facility titled 2.1 Self Administration of Medications last revised 6/1/24 was reviewed. The policy reflected, Procedure: 1. Facility should comply with the facility policy applicable law and the State Operations Manual with respect to resident self-administration of medications. The facility policy reflected in conjunction with the interdisciplinary care team, should assess and determine . whether self-administration is safe and clinically appropriate, based on the resident's functionality and health condition, The policy further reflected the facility must educate residents on possible side effects of the medication, ensure that the resident can correctly administer and address the storage of the medication. The facility policy also reflected 4. Facility should regularly observe the resident self-administering medications. And 8.the interdisciplinary care team should routinely assess the resident's cognitive, physical and visual ability to carry out this responsibility per facility policy. 10. Facility staff should document the self-administering of medications on the Medication Administration Record (MAR) . And 11. Facility should document the self-administration and self-storage of medications in the resident's care plan. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Notes and the Assessment section of the EMR did not reveal any documentation the Resident had been assessed, educated, or monitored for proper and safe use of the inhaler. Review of MARs for R66 from 5/5/25 through 6/13/25 reflected documentation of one self-administration on 5/22/25 even though R66 reported using the inhaler sometimes a couple of times a day. On 6/13/25 at 9:54 AM the self-administration of medication by R66 was discussed with the Director of Nursing (DON). The DON was informed the EMR did not reveal the assessments and monitoring indicated by the facility policy had been conducted. The DON reported that if the information was not evident it likely was not there. As of survey exit no additional information had been provided.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to respect the dignity of one (R224) of two residents reviewed for dignity. Findings include: Resident #224 (R224) Review of the Minimum Data Set (MDS) dated [DATE] for R224 revealed she was always continent of bowel and bladder. R224 required substantial/maximal assistance for toilet transfers. In an interview on 6/10/25 at 3:10 PM, R224 reported she has had to wait for long periods of time for the call lights to be answered so she can get assistance with toileting. The longest time she waited for the call light to be answered was about an hour and soiled her pants because she could not wait that long. A couple staff at night will tell her to just go in her brief if she cannot hold it and not to worry about it. If you have to go, just go they told her. R224 reported it makes her feel bad when she wets inside her brief even though the staff are very kind about it and will clean her up. In an interview on 6/13/25 at 10:41 AM, the Director of Nursing (DON) reported she had been addressing call light times in meetings and daily. The audits she had done so far were not problematic. A reasonable time for call lights to be answered is about 5-10 minutes. In an interview on 6/13/25 at 11:37 AM, the NHA reported she was aware of call light concerns in the facility and no ad hoc was done yet.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to answer call lights in a timely manner for one Resident (R224) and those who attended the Resident Council meeting. This deficient practice affects all residents who reside at the facility. Findings include: Review of the Resident Council Minutes dated 4/24/25 revealed call light concerns especially on the 2nd and 3rd shift. Number of Residents who share concern: *leave light on until need is met! No number or specific residents listed. There were 13 residents who were documented as attending the meeting. The meeting minutes were signed by the Nursing Home Administrator (NHA). Review of an email correspondence provided dated 4/25/25 revealed the Activities Director notified the previous Director of Nursing (DON) of the call light concerns. . However, the issue of Call Lights has come up again. They feel that they are not being answered in a timely manner. Typically, 2nd or 3rd shift but can be all over the place. Both residents from [NAME] and Yellow Units had the same complaint. They also said that staff will come in to answer the call light, say that they will let other staff know or that they will be right back, the need is never met. If staff could leave the call light on until the need is met, that would be best. Review of the Resident Council Minutes dated 5/29/25 revealed the Old business of call lights was not resolved to satisfaction. Seven residents were in attendance. The meeting minutes were signed by the NHA. Resident #224 (R224) Review of the Minimum Data Set (MDS) dated [DATE] for R224 revealed she was always continent of bowel and bladder. R224 required substantial/maximal assistance for toilet transfers. In an interview on 6/10/25 at 3:10 PM, R224 reported she has had to wait for long periods of time for the call lights to be answered so she can get assistance with toileting. The longest time she waited for the call light to be answered was about an hour and she soiled her pants because she could not wait that long. Review of the Call Light logs for R224 from 6/5/25 to 6/12/25 revealed the following call wait times: 6/5/25 at 6:28 AM, 27:14 minutes 6/5/25 at 7:48 AM, 40:31 minutes 6/5/25 at 12:23 PM, 24:22 minutes 6/5/25 at 8:01 PM, 20:40 minutes 6/6/25 at 7:58 AM, 40:37 minutes (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/6/25 at 9:30 AM, 22:33 minutes 6/6/25 at 1:48 PM, 30:01 minutes 6/8/25 at 9:10 PM, 36:17 minutes 6/9/25 at 7:31 PM, 23:06 minutes 6/10/25 at 11:14 AM, 41:46 minutes 6/11/25 at 5:16 AM, 35:17 minutes 6/11/25 at 7:55 AM, 45:49 minutes In an interview on 6/11/25 at 4:35 PM, Certified Nursing Assistant (CNA) S she is aware of R224's concerns about long call light wait times. CNA S reported she told the DON of R224's concerns, and the DON did meet with the resident. In an interview on 6/13/25 at 10:41 AM, the Director of Nursing (DON) reported she had been addressing call light times in daily meetings. The audits she had done so far were no problematic. A reasonable time for call lights to be answered is about 5-10 minutes. In an interview on 6/13/25 at 11:37 AM, the NHA reported she was aware of call light concerns in the facility and no ad hoc was done yet. The NHA gave the task to the Admissions Coordinator who did not make it to the Quality Assurance Meeting yet. The NHA reported she did not receive individual grievances resulting from the resident council meetings and only gets them once they are resolved to make sure they are complete.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately notify the physician/provider in a timely manner of a fall with injury for 1 of 2 residents (R15) reviewed for falls. Findings include: A review of R15's admission Record, dated 6/12/25, revealed they were a [AGE] year-old resident that was admitted to the facility on [DATE]. In addition, R15 had multiple diagnoses that included a traumatic subdural hemorrhage (brain bleed) with a loss of consciousness. A review of R15's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 2/21/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R15 was cognitively intact. During an interview on 06/10/25 at 12:30 PM, R15's spouse stated R15 had been in the hospital on and off five times since November 2024. Even though R15's MDS indicated he was cognitively intact, his spouse was interviewed because he had just returned to the facility after an 11-day hospital stay and was not alert and/or oriented at the time. A review of R15's progress notes, dated 11/13/24 to 6/11/25, revealed the following: - Incident Note, dated 11/18/24, revealed, CNA (certified nursing assistant) observed resident on the floor of bathroom at 0725 am. Resident was lying on his back with legs out in front of him and his head against the bathroom door . skin tear to L (left) elbow and swelling to back of head noted . change of condition place in dr. (doctor) book . - Nurse's Notes, dated 11/21/24, revealed, wife called from hospital to give update . resident is being admitted to hospital- elevated white count (high white blood cell count- potentially a reaction to an infection, tissue damage, or swelling)), small intercranial bleed (brain bleed) . A review of R15's Nursing/Physician Communication form, dated 11/18/24, revealed that on 11/18/24 at 7:25 AM, R15 had an unwitnessed fall and was found laying on the bathroom floor next to the door. It also revealed R15 had a skin tear to the left elbow and R15 was complaining of a headache. However, the form did not reveal that R15 also had swelling to the back of the head at the time they were found. In addition, R15's Nursing/Physician Communication form revealed Nurse Practitioner (NP) R was made aware of the incident on 11/20/24 (two days after the incident). A further review of R15's medical record failed to reveal that the physician/provider had been notified prior to 11/20/24 when NP R had noted the fall on the Nursing/Physician Communication form. During an interview on 06/13/25 at 4:57 PM, the Nursing Home Administrator stated she did not know if the physician was notified of R15's fall prior to 11/20/24. She stated the physician should have been notified at the time of the fall. In addition, the NHA stated if the surveyor could not find the documentation in R15's medical record that the physician/provider had been notified of R15's fall prior to 11/20/24, then they probably had not been notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/25 at 05:02 PM, Clinical Care Coordinator (CCC) E stated the nurse should have called the physician on 11/18/24 after R15 fell. She stated if it was after hours, the on-call physician/provider should have been notified. CCC E stated if that was the case (the fall occurred after hours, and the on-call physician/provider was notified) then the nurse would have also placed the notification in the Doctor's Book so the attending physician would know about the fall when he next came in for physician rounds. She stated the nurse should have documented the phone notification in the progress notes. CCC E stated she did not know personally if the physician/provider had been notified of R15's 11/18/24 fall prior to 11/20/24 because she was not an employee of the facility at that time. However, she did state that if the notification was not documented in R15's medical record, then it probably did not occur.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of neglect to the state survey agency for 1 of 19 sampled residents (R1). Findings include: A review of the facility's Abuse, Neglect and/or Misappropriation of Resident Funds or Property and Exploitation Prohibition policy and procedure, revised February 2025, revealed, Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Serious Bodily Injury means an injury involving extreme physical pain . requiring medical intervention such as surgery, hospitalization, or physical rehabilitation . A review of the facility's Abuse, Neglect and/or Misappropriation of Resident Funds or Property and Exploitation Prohibition policy and procedure, revised February 2025, further revealed, The Administrator or his/her designee will notify the State Agency and any other agencies (i.e., law enforcement, adult protective services) as appropriate of alleged violations involving abuse. neglect, misappropriation of resident property and injuries of unknown source. Serious bodily injury is reported immediately but not later than 2 hours after forming the suspicion if the allegation involves abuse or results in serious bodily injury . Resident #1 A review of R1's admission Record, dated 6/12/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R1's admission Record revealed they had multiple diagnoses that included cerebral palsy, epilepsy, abnormal posture, torticollis (a rare condition in which the neck muscles contract causing the head to twist to one side), and scoliosis. A review of R1's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/14/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 12 which revealed R1 was moderately cognitively intact. During an interview on 06/12/25 at 09:50 AM, R1 stated through short statements and yes/no answers that in February 2025 she rolled out of bed while staff were doing a bed bath. She stated staff rolled her to the side and she kept going until she was on the floor. R1 stated one staff member was present and giving her the bed bath. She stated usually only one staff member provides care to her, including bed baths. R1 denied the facility uses two staff members for her care. R1 stated after she fell out of bed onto the floor she had difficulty breathing and pain. She stated staff called an ambulance and staff stayed with her until the ambulance arrived. R1 stated she had several fractured ribs and a hip fracture. She stated she was in the hospital for several days, but did not have surgery. A review of R1's Fall Risk Assessment, dated 12/10/24, revealed R1 scored a 15 (Moderate Risk). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R1's Activities of Daily Living (ADL) Care Plan, dated 9/28/20 and revised on 12/27/23, revealed R1 required 2 staff participation for repositioning and turning in bed (date initiated: 4/6/23). However, R1 only needed total assistance of one person with brief changes and using the bed pan per the care plan. A review of R1's Nurse's Notes, dated 2/7/25, revealed, Resident observed laying on her left side on the floor next to the bed. Resident moaning with a snort like breathing. Resident complained of pain to back. Resident assessed, large forming bump noted on back of head. Hump in the middle of the bed observed Resident sent out to the emergency room for evaluation and treatment. Resident assessed . A review of the hospital's Internal Medicine Daily Inpatient Progress Note, dated 2/17/25, revealed on 2/7/25 R1 was admitted to the hospital due to rib fractures and a hip fracture after a fall. She presented to the ER (emergency room) after falling out of bed while receiving a bath at her facility. Workup revealed multiple rib fractures as well as a hip fracture. Additionally she was found to have a new LLL (left lower lobe) subsegmental PE (pulmonary embolism- a blood clot in the lung) and a very small left-sided pneumothorax (a condition that can be caused by a blunt or penetrating injury (e.g., from fractured ribs) where air leaks into the space between the lung and chest wall and causes the lung(s) to collapse) . A review of Certified Nursing Assistant (CNA) D's typed statement, undated, revealed she was cleaning R1 up because R1 had a bowel movement. She rolled R1 onto her right side to clean her up. CNA D stated she needed more washcloths, so she turned around to grab some more washcloths. She stated when she turned back around, she heard R1 make a grunting/growling noise and R1 was rolling off the bed. CNA D stated she could not catch her in time before she rolled off the bed completely. CNA D stated she had checked R1's kardex (a summary of a resident's care needs) before providing care and she noticed R1 was one assist for toileting and two assist for transfers. CNA D stated she did not remember if she checked R1's bed mobility assistance on the kardex. She then expressed guilt/remorse that the incident occurred. During an interview on 06/12/25 at 2:00 PM, the Nursing Home Administrator (NHA) stated she definitely had an investigation for this incident. She stated she did not report the incident to the state survey agency (SSA) because Regional Nurse Consultant (RNC) Q told her not to because the facility determined that the reason that R1 fell off the bed and onto the floor was a mattress issue from a hump in the mattress and not the result of anything that was reportable. During a second interview on 06/13/25 at 01:25 PM, the NHA stated CNA D had to complete training on safe resident handling because she rolled her (R1) away from her. The NHA stated if CNA D would have rolled her (R1) towards herself (CNA D), she would have caught her and R1 would not have rolled off the bed. The NHA further stated if there had been a hump/lump in the mattress staff should roll the resident over it and have another staff member on the other side of the mattress to make sure the resident did not roll off the bed.

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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 interview and record review, the facility failed to appropriately transfer and/or discharge two residents (R69, R70) of two residents reviewed for discharges. Findings include: Resident #69 (R69) Review of the MDS dated [DATE] for R69 revealed in section A2105, R69's discharge status was 04. Short-Term General Hospital (acute hospitals, IPPS), indicating R69 was discharged to the hospital. Review of a Nursing Progress note dated [DATE] for R69 revealed he was discharged with his son to an Assisted Living Facility. Review of a document titled Discharge Instructions dated [DATE] for R69 revealed: admission (sic) In Progress, with no locked date. The document was not complete with the reason for the discharge and where the resident was discharged to, and no document signed by the resident indicating he or his representative acknowledged or received discharge information/instructions. No Home Care Agency information was documented. No other discharge form was in the electronic medical record (EMR). Review of the Progress Notes for R69 dated [DATE] revealed: Reviewed medications and discharge instructions with son. All nonreturnables (sic) sent with son. Reviewed upcoming doctor appointment and home care agency follow up. No questions asked after opportunity offered. Resident discharged with son via private vehicle to [Assisted Living]. Review of the EMR for R69 revealed no discharge summary or recap of stay. In an interview on [DATE] at 8:35 AM, RN Q reported R69 did go home and was not sure why R69 would be flagged for hospitalization. RN Q then verified the Social Worker documented R69 went back to the hospital, but he actually went home. Resident #70 (R70) Review of the MDS dated [DATE] for R70 revealed in section A2105, R70's discharge status was 13. deceased and indicated as a death in the facility. Review of the electronic medical records (EMR) for R70 revealed the resident had a change of condition and the Emergency Medical Services (EMS) was called. There was no documentation to show the resident left the facility and went to the hospital and no documentation to show he died in the facility. Review of a Bed Hold & Leaves of Absence document dated [DATE] revealed a request to hold a bed. Review of the Physician Orders for R70 revealed no orders for the resident to be discharged or sent to the hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 8:35 AM, MDS Coordinator/Registered Nurse (RN) Q reported R70 did go to the hospital and died there. R70 should not have been documented as a death in the facility. R70 acknowledged there were no transfer forms in the EMR indicating R70 left the facility accompanied by EMS. A request for an admission, transfer and discharge policy was requested via email on [DATE] at 2:47 PM and was provided with a copy of an alleged power point slide provided to staff during training when hired according to the Clinical Nurse Consultant U with a date of 2017 that revealed: Transfers to Hospital: Complete Resident Transfer Form. -What do you send with the resident? - Transfer Form, Face sheet, Med List, Advance Directives, Bed Hold Policy. -Review checklist. Notify: DON (Director of Nursing), Physician, Responsible Party. Nursing Note: - Change in Condition. Another power point slide dated 2017 revealed: discharge: Interdisciplinary Discharge Summary. Post- Discharge Plan of Care- Review Post-Discharge POC (plan of care), - review medications/treatments with resident/family, - Provide list of medications/treatments, - instruct resident to sign form and provide a copy of the form to the resident. Nursing Discharge Note Discharge Resident in Vision (an electronic medical record not used by the facility), - Discontinue orders, resolve care plans. In an interview on [DATE] at 4:25 PM, Clinical Nurse Consultant (CNC) U reported they do not have formal policies for admissions, transfers and discharges and just follow the standards of practice. CNC U then reported the standards of practice should be followed for documentation and there should be an order for discharges.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit the Minimum Data Set (MDS) assessments timely for (R27, R35, R222 R224) of 4 residents reviewed for MDS transmissions. Findings include: Resident #27 (R27) Review of the MDS in the Electronic Medical Record (EMR) revealed R27 was due for her yearly annual assessment and had an ARD (assessment reference date)/Target date of 3/20/25. This assessment was completed on 6/5/25. Resident #35 (R35) Review of the MDS in the EMR revealed R35 was due to her yearly annual assessment and had an ARD (assessment reference date)/Target date of 5/4/25. This assessment was completed on 6/6/25. In an interview on 6/13/25 at 8:35 AM, MDS Coordinator/Registered Nurse (RN) Q confirmed R27 and R35's annual MDS assessments were over 120 days old. RN Q reported she was not sure what happened with R27's assessment but did find that R35's assessment was not flagged that it was due, or that it was late. RN Q reported R27 had an annual assessment that was missed and submitted an assessment based on the March data in the EMR. RN Q reported they need a new tracking system, so they do not miss any assessments. Resident #222 (R222) Review of the EMR for R222 on 6/11/25 revealed her ARD - 5-day assessment (5/29/25) was flagged as being 5 days overdue and her admission assessment dated [DATE] was flagged as 13 days overdue with a status of in progress. In an interview on 6/13/25 at 8:35 AM, RN Q reported R222's entry was not signed off until 6/6/25 and was one day late. The EMR showed it was 13 days overdue, and her entry was 5/29/25, which was submitted on 6/6/25. R222's Medicare started on 6/5/25 for a look back and was submitted on 6/11/25. Resident #224 (R224) Review of the EMR on 6/11/25 for R224 revealed she had a 5-day admission assessment due for a 5/30/25 entry to the facility and was flagged as being 5 days overdue. On 6/11/25 the status was showing it was in progress. In an interview on 6/13/25 at 8:35 AM, RN Q reported R224's MDS Entry submission was a day late but her Admission assessment was fine. When queried about the EMR flagging it was 5 days overdue, RN Q then clarified that it was in fact overdue. RN Q reported R224 entered the facility on 5/30/25 and the MDS was submitted on 6/6/25 and therefore it was submitted one day late. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/13/25 at 12:26 PM, the Nursing Home Administrator (NHA) reported she was told by RN Q that there were some late assessments, but they were working on it.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS) for two Residents (R70 and R69) of three residents reviewed for closed records. Findings include: Resident #70 (R70) Review of the MDS dated [DATE] for R70 revealed in section A2105, R70's discharge status was 13. deceased and indicated as a death in the facility. Review of the Electronic Medical Records (EMR) for R70 revealed the resident had a change of condition and the Emergency Medical Services (EMS) was called. There was no documentation to show the resident left the facility and no documentation to show he died in the facility. In an interview on [DATE] at 8:35 AM, MDS Coordinator/Registered Nurse (RN) Q reported R70 did go to the hospital and died there. R70 should not have been documented as a death in the facility. R70 acknowledged there were no transfer forms in the EMR indicating R70 left the facility accompanied by EMS. Resident #69 (R69) Review of the MDS dated [DATE] for R69 revealed in section A2105, R69's discharge status was 04. Short-Term General Hospital (acute hospitals, IPPS), indicating R69 was discharged to the hospital. Review of a Nursing Progress note dated [DATE] for R69 revealed he was discharged with his son to [Name omitted] which is an Assisted Living Facility. In an interview on [DATE] at 8:35 AM, RN Q reported R69 did go home and was not sure why R69 would be flagged for hospitalization. RN Q then verified that the Social Worker documented R69 went back to the hospital, but he went home. A request for the facility's policy for MDS was requested and was provided with an MDS Completion Guideline dated [DATE] revealed it was not updated, reviewed, or revised since then.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an annual Preadmission Screening/Annual Resident Review (PASARR) Level I Screening and Level II Evaluation timely for 1 of 1 resident (R9) reviewed. Findings include: A review of R9's admission Record, dated 6/12/24, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R9 had multiple diagnoses that included dementia, depression, and narcissistic personality disorder. A review of R9's medical record, dated 5/1/24 to 6/11/25, revealed R9 last had a PASARR Level II Evaluation completed on 5/15/24. However, there was not any documentation in R9's medical record that a PASARR Level I Screening and/or Level II Evaluation had been completed since then (they should have been completed prior to 5/15/25). During an interview on 06/11/25 at 02:10 PM, Social Worker (SW) A stated per her tracking tool R9's PASARR Level I Screening was due on 5/1/25. She stated she knew it was late, but had not completed it yet. A review of SW A's PASARR tracking tool, dated 6/11/25, confirmed that R9's PASARR Level I Screening and Level II Evaluation were due on 5/1/25. During an interview on 06/11/25 at 2:40 PM, the Nursing Home Administrator (NHA) stated the facility was currently addressing late PASARR Screenings and Evaluations in their Quality Insurance and Performance Improvement (QAPI) Committee (a committee that self-identifies issues in the facility and works to correct them). She stated SW A identified this issue and notified the QAPI Committee last month (May 2025). The NHA stated SW A was aware that she was behind in getting her PASARR Level I Screenings and Level II Evaluations completed because she depends on the Medical Director (MD C) to do the Level II Evaluations. The surveyor requested a copy of anything that the NHA had to demonstrate that the facility had been addressing the timeliness of PASARR Screenings and Evaluations in QAPI, including the steps they had taken to correct the issue. During a second interview on 06/12/25 at 9:40 AM, the surveyor requested from the NHA a copy of anything that they may have demonstrating that the facility had been addressing the timeliness of PASARR Screenings and Evaluations in QAPI, including the steps they had been taking to correct the issue. A review of the facility's Performance Improvement Plan (PIP), dated 6/12/25, revealed the facility identified timely completion of PASARR's (Level I Screenings and Level II Evaluations) as a concern in QAPI on 5/14/25. However, the completion of all outstanding PASARR's was not started until 6/11/25 (during the annual survey) and audits will not be started until 6/16/25 (after the completion of the annual survey). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a third interview on 06/13/25 at 8:50 AM, the NHA verified that the facility had identified a concern in QAPI on 5/14/25 with the timeliness of the completion of the PASARR Level I Screenings and Level II Evaluations. She stated that the concern was not worked on for all residents until 6/12/25 (during the annual survey).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a person-centered Care Plan for one (R224) of two residents reviewed for Care Plans. Findings include: Resident #224 (R224) Review of a Face Sheet revealed R224 admitted to the facility on [DATE] with pertinent diagnoses of fusion lumbar spine, urinary tract infection (UTI), and fractured lumbosacral spine and pelvis. Review of the Minimum Data Set (MDS) dated [DATE] for R224 revealed she was always continent of bowel and bladder. R224 required substantial/maximal assistance for toilet transfers. Review of the Care Plan for R224 revealed: Focus: I have indwelling catheter, initiated on 5/30/25 and revised on 6/2/25 by the MDS Coordinator. The MDS reflects R224 is continent. Focus: At risk for infection related to indwelling catheter, initiated on 6/2/25. Focus: ADL (activities of Daily Living) Self Care Performance . Interventions/Tasks: TOILET USE: I require 1 staff participation to use toilet, initiated 5/30/25 and last revised 6/2/25. During an observation and an interview on 6/10/25 at 3:10 PM, R224 reported she has had to wait for long periods of time for the call lights to be answered so she can get assistance with toileting. The longest time she waited for the call light to be answered was about an hour and soiled her pants because she could not wait that long. A couple staff at night will tell her to just go in her brief if she cannot hold it and not to worry about it. If you have to go, just go they told her. R224 reported it makes her feel bad when she wets inside her brief even though the staff are very kind about it and will clean her up. R224 did not have an indwelling catheter.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to revise the Care Plan for two facility residents (R66 and R26) who had documented changes in care following admission to the facility. R66 Review of the Electronic Medical Record (EMR) reflected R66 was admitted to the facility 5/1/25 with pertinent diagnoses that included Acute Respiratory Failure and Chronic Obstructive Pulmonary Disease (COPD) On 6/11/25 at 9:43 AM and again on 6/12/25 at 2:34 PM, R66 was observed in a recliner chair with an Albuterol multidose inhaler on the over-the-bed table next to the Resident. R66 reported he used the inhaler sometimes a couple of times a day. R66 reported staff had not asked him if he had used it or how often. R66 indicated staff never asked him anything about the inhaler. Review of the EMR Doctor's Orders reflected an order for Ventolin HFA Inhalation Aerosol Solution 90 micrograms (mcg) (Albuterol Sulfate) 2 puff inhale orally every 6 hours as needed for COPD/wheezing. May leave at bedside with a start date of 5/5/25. Review of the Care Plan for R66 did not reflect a plan of care for the assessment, monitoring of self-administration of medication, or the expectation of staff monitoring and documentation. R26 Review of the Electronic Medical Record (EMR) reflected R26 admitted to the facility 5/19/25 with diagnoses that included a fracture and a history of repeated falls. The medical record reflected a urinary catheter had been inserted during admission. Review of the EMR Progress Notes for R26 reflected an entry 6/2/25 at 5:42 PM of urine with increased cloudiness, sediment . and foul smelling. The entry reflected a lab specimen was obtained and transported to the lab for testing. Review of the laboratory urinalysis report dated 6/2/25 reflected an elevated white blood cell count (one of the signs of an infection). The EMR Progress Notes for R26 reflected an entry of 6/3/25 at 12:43 PM that the Lab had been called and the specimen was going to culture. Further documentation of 6/3/25 reflected antibiotic therapy had been initiated for a UTI. Review of the Care Plan for R26 did not reflect the Care Plan had been revised for a UTI with antibiotic administration. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy provided by the facility titled Care plan preparation, long-term care dated May 19, 2025 was reviewed. The policy reflected A care plan is an individualized, written action plan for a resident's care, must be person-specific and guides a resident's care from admission to discharge. The policy reflected that the care planning is driven by a resident's conditions and issues as well as a resident's unique characteristics. The policy reflected that the interdisciplinary team collaborates with the resident and reviews and revises the care plan as necessary, to meet the resident's needs throughout the stay in the facility. The policy reflected Special Considerations If you must revise your plan as the resident's condition changes fill out a new care plan and add it to the medical record. The policy reflected sign and date the care plan whenever you make new entries to keep the plan current and to maintain accountability for planning the resident's care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) assess, monitor, and act upon abnormal findings, 2) have medications available timely after admission, 3) timely follow up to labs and/or diagnostics, and 4) document accurate skin assessments for three residents (R70, R224, and R6) of 4 residents reviewed for quality of care. Findings include: Resident #70 (R70) Review of the Electronic Medical Records (EMR) for R70 revealed he admitted to the facility on [DATE] and had diagnoses of chronic diastolic (congestive) heart failure (CHF), sepsis, pressure ulcer, and Alzheimer's disease. Review of the Minimum Data Set (MDS) dated [DATE] for R70 revealed in section A2105, R70's discharge status was 13. deceased and indicated R70 died in the facility. Review of the Nursing Progress notes for R70 dated [DATE] at 3:38 PM revealed R70 had a change of condition, and the Emergency Medical Services (EMS) was called. Resident observed unable to hold himself up in the chair and could not help during 2-person transfer. Resident was able to answer questions very slurred. Resident then began to cough up coffee ground color emesis. VS (vital signs) taken 66/44 (blood pressure), 80 (pulse), 97.9 (temperature), 18 (respirations), 87% (oxygen saturation). LS (lung sounds) clear. Abdominal pain noted in RUQ and LUQ (right and left upper quadrant). There was no documentation to show the resident left the facility and went to the hospital and/or no documentation to show he died in the facility. In an interview on [DATE] at 8:35 AM, MDS Coordinator/Registered Nurse (RN) Q reported R70 did go to the hospital and died there, not at the facility. R70 should not have been documented in the MDS as a death in the facility. R70 acknowledged there were no transfer forms in the EMR indicating R70 left the facility accompanied by EMS. Review of the Physician Orders for R70 revealed no orders for the resident to be discharged or sent to the hospital. Review of the Physician Orders for R70 revealed: 1. 2 Grams (GM) Cefazolin Sodium Dextrose Intravenous solution every 8 hours was ordered [DATE] at 7:51 PM. (For sepsis) 2. Blood pressure, temperature, pulse, respirations, and oxygen on admission and readmission, every shift obtain vital signs. No parameters ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Coccyx wounds: Cleanse with normal saline, cut aquacel to fit wounds and cover with optifoam dressing. Change daily. Start date was [DATE], no treatment documented on [DATE]. 4. No orders for oxygen. 5. Braden Assessment Completed the Braden Assessment (tool used to assess risk for developing pressure ulcers) in Assessment tab (sic) ordered [DATE]. 6. Review of the Physician Orders revealed: 7. On [DATE], Weekly Skin Audit, every day shift, every Sat . (Saturday) was ordered and discontinued on [DATE]. 8. On [DATE], Weekly Skin Audit, every day shift every Tue . (Tuesday) was ordered and discontinued on [DATE]. Medication not available Review of a Nursing Progress note dated [DATE] at 8:15 AM for R70 revealed: Nurse called pharmacy regarding IV medication and pharmacy confirmed it will be drop shipped to facility in the next 4 hours and pump will be drop shipped to (sic). Patient to receive IV antibiotic dose as soon as its received. (12-16 hours post admission.) No documentation to show the physician was notified the prescribed antibiotic had not been received at the facility and administered as ordered. Vital signs Review of the [DATE] Medication Administration Record (MAR) for R70 revealed vital signs were checked as done twice a day but the Vital signs report is documented as either done once a day or every other day. No documentation to show R70 was a CO2 (carbon dioxide retainer as seen in patients with chronic obstructive pulmonary disease (COPD). Review of the vital sign for R70 were as follows and not completed most days as ordered (Normal: SpO2 ?95%): [DATE] 12:05 90.0% Room Air (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] 08:32 90.0% Room Air [DATE] 14:10 90.0% Room Air [DATE] 11:55 96.0% Room Air [DATE] 02:46 89.0% Room Air [DATE] 00:47 91.0% Room Air [DATE] 09:45 91.0% Room Air [DATE] 12:31 91.0% Room Air [DATE] 08:36 90.0% Room Air [DATE] 09:07 90.0% Room Air [DATE] 13:39 90.0% Room Air [DATE] 23:27 92.0% Room Air [DATE] 12:03 90.0% Room Air [DATE] 09:00 90.0% Room Air [DATE] 23:46 92.0%Room Air 3/ 26/2025 12:10 91.0% Room Air [DATE] 02:25 92.0% Room Air Blood Pressures for R70 were as follows and no follow up to the start of the abnormally low blood pressure (since admission) documented on [DATE] at 8:31 AM. [DATE] 12:05 98 / 54 mmHg Sitting l/arm [DATE] 08:32 93 / 53 mmHg [DATE] 08:31 93 / 53 mmHg [DATE] 06:21 112 / 67 mmHg [DATE] 14:10 107 / 68 mmHg Lying l/arm [DATE] 11:55 107 / 71 mmHg Sitting l/arm [DATE] 02:46 118 / 73 mmHg Sitting l/arm (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Physician Progress note dated [DATE] and electronically signed on [DATE] for R70 revealed no indication the practitioner was aware of R70's trend of low oxygen levels. Exam: Respiratory: auscultation: no rales, rhonchi, or wheezes. Problems: Acute hypoxemic respiratory failure, Status: Active, onset, noted (assessed) Community acquired pneumonia of left lower lobe of lung, Status, onset [DATE], . Plan does not address low oxygen levels. Review of the Order Summary for R70 revealed no orders or standing orders for oxygen. Review of the Care Plan for R70 revealed no focus or interventions for oxygen. In an interview on [DATE] at approximately 4:15 PM, the Clinical Care Coordinator (CCC) R reported R70 had CHF and therefore having an oxygen level at 89-90% was okay for him. CCC R reported the facility had standing orders for oxygen levels of 89% and below. Residents are to receive 2 liters of oxygen via nasal cannula across the board but was unable to provide the orders before the end of this survey. CCC R reported normal oxygen levels are 89% and above and are to notify the physician if it is below 89%. In an interview on [DATE] at 4:16 PM, the Director of Nursing (DON) reported oxygen levels should be individualized per residents and if they have CHF, it could be normal to have an oxygen level below 90%, but there should be an order for it and an evaluation. Vital Signs-Acceptable Ranges for Adults . Pulse oximetry (SpO2) Normal: SpO2 ?95% Respirations 12 to 20 breaths/min, deep and regular . [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 500). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Completing a health assessment and physical examination is an important step toward providing safe and competent nursing care. The nurse is in a unique position to determine each patient's current health status, distinguish variations from the norm, and recognize improvements or deterioration in the patient's condition. Nurses must be able to recognize and interpret each patient's behavioral and physical presentation . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pp. 516-517). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, An alteration in vital signs signals a change in physiological function. Assessment of vital signs provides data to identify nursing diagnoses, implement planned interventions, and evaluate outcomes of care .Verify and communicate significant changes in vital signs. Baseline measurements provide a starting point for identifying and accurately interpreting possible changes. When VS appear abnormal, have another nurse or health care provider repeat the measurement to verify readings. Inform the charge nurse or health care provider immediately, document findings in your patient's record, and report changes to nurses during hand-off communication (TJC, 2020). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E Book (p. 467-468). Elsevier Health Sciences. Kindle Edition. Coccyx Wounds (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nursing Progress note dated [DATE] at 8:15 PM for R70 revealed the resident arrived at the facility and had a small open area to his coccyx with mediplex applied and to be changed every 3 days. Review of a Nursing Management progress note dated [DATE] for R70 revealed: Red area on sacrum is not open at this time as reported on admission assessment, [Physician] observed area with this writer. Protective barrier cream to area for prevention. Review of the Clinical Assessment tab for R70 revealed no Braden Assessment was completed. Review of the Clinical Assessment tab for R70 revealed the first Skin Assessment documented was on [DATE]. Review of a Nursing Progress note dated [DATE] for R70 revealed: [Physician] in today. New orders for wound care to coccyx . No wound assessment documented. Review of the Physician Orders for R70 revealed on [DATE] an order for : Coccyx wounds: Cleanse with normal saline, cut aquacel (wound treatment) to fit wounds and cover with optifoam dressing. Change daily. Review of the April Treatment Administration Record (TAR) for R70 revealed his first coccyx wound dressing was done [DATE] (one day after the nurse documented there was a new order on [DATE].) No dressing change was documented on [DATE]. No documentation in the EMR that a clinical assessment, physician progress note and/or skin/wound note, or treatment order was in place to address the sacral wound that worsened in 12 days between [DATE] and [DATE] after admission. Review of a Late Entry Nursing Management Skin/Wound Note dated [DATE] for R70 revealed he had a left coccyx wound that measured 3 cm (centimeters) x 2 m (sic) x <0.1 cm, wound bed pink without s/s (signs and symptoms) of infection. The right coccyx measured 3.5 cm x 1.5 cm x <0.1 cm, wound bed pink without s/s of infection. Review of the Care Plan for R70 revealed on [DATE] a care plan for a pressure injury to the left and right coccyx was initiated. (18 days after admission.) In an interview on [DATE] at 4:16 PM, the Director of Nursing (DON) reported there should be more information in the EMR for R70 and reported the care plans should reflect the residents needs timely. Skin assessments should be done upon admission and weekly. They do not have policies for skin assessments, and it should be the standards of practice for documentation. It is also the standard of practice to have an order to be discharged . R224 Resident #224 (R224) Review of a Face Sheet revealed R224 admitted to the facility on [DATE] with pertinent diagnoses of fusion lumbar spine, urinary tract infection (UTI), and fractured lumbosacral spine and pelvis. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) dated [DATE] for R224 revealed she was always continent of bowel and bladder. R224 required substantial/maximal assistance for toilet transfers. Review of the Care Plan for R224 revealed: Focus: I have indwelling catheter, initiated on [DATE] and revised on [DATE] by the MDS Coordinator. The MDS reflects R224 is continent. Focus: At risk for infection related to indwelling catheter, initiated on [DATE]. Focus: . ADL (activities of daily living) . Interventions: . TOILET USE: I require 1 staff participation to use toilet, initiated [DATE]. During an observation and interview on [DATE] at 1:14 PM, R224 reported she went to the bathroom the day before and her hips popped and it hurt like the dickens. R224 reported staff did not use a gait belt to assist with her transfer but staff did hold on to her post-surgical support brace that was observed wrapped around her back and her abdomen. R224 was sitting in her wheelchair with ice packs to both sides of her hips. R224 reported her biggest concern was the communication between the hospital and the facility regarding her medications she needed. At this time the nurse came in to tell R224 that the Physician ordered x-rays on her hips. No urinary catheter was observed. During an observation and an interview on [DATE] at 3:10 PM, R224 reported she was on antibiotics prior to admission for a urinary tract infection (UTI) and they were not available upon admission to the facility. R224 denied having a urinary catheter. Urine Culture Review of a urine culture collected [DATE] (day of admission) that last resulted on [DATE] for R224 revealed Citrobacter freundii bacteria and reported This is an edited result. Previous organism was Gram negative bacilli on [DATE]. R224 was to start Bactrim (antibiotic) for 7 days per undated signature. Review of a Nursing Progress note dated [DATE] at 12:38 PM for R224 revealed: Has complaints of needing an antibiotic for a UTI and states that she was on an antibiotic prior to leaving the hospital. Attempting to obtain a clean catch urine, though resident states that she is incontinent more times than not. Doctor made aware of situation and to address this during visit today. Review of a Nursing Progress note dated [DATE] for R224 at 7:17 PM revealed: Resident continues with occasional complaints of needing to be on an antibiotic for a UTI. Husband brought this nurse a specimen cup of urine which was warm, and clear red in color. No particulates or any debris was seen. Urine was brought for chemstrip (sic) testing. Chemstrip (sic) was dipped into the cup and every testing field was stained into an orange color, except for glucose which remained blue. Paper towel used also turned an orange color. Note left for doctor to follow up with resident during his visit. Review of the Nursing Progress notes dated [DATE] at 12:36 PM for R224 revealed: Urine culture results received . new orders received for . Bactrim DS (double strength) BID (twice a day) x 7 days. Review of the June Medication Administration Record (MAR) for R224 revealed Bactrim was ordered on [DATE] and at 7:00 PM and she received her first dose. (3 days after admission.) Review of the Care Plan for R224 initiated [DATE] revealed: Focus: At risk for infection related to indwelling urinary catheter. Resident did not have an indwelling catheter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: I have Urinary Tract Infection, initiated [DATE]. Review of the Order Summary for R224 revealed she had no orders for a urinary catheter and no orders to discontinue a urinary catheter X-ray Review of R224's EMR on [DATE] revealed no x-ray results were documented or scanned into the computer. In an interview on [DATE] at 3:45 PM, Licensed Practical Nurse (LPN) H was questioned about the results of R224's x-ray and did not know what the status was. LPN H then looked into the facilities EMR and could not find any x-ray results. LPN H then looked into the hospital medical records system and found the x-ray results for R224 and provided a copy. There was no documentation or indication the results were followed up on and/or informed the medical provider of the results. In an interview on [DATE] at 4:08 PM, Physical Therapist (PT) T reported she was aware that x-rays were ordered for R224 but did not know the results at this time. PT T reported R224 is to be transferred with a gait belt and is a standby assist with contact guard (it would be helpful to indicate if PT T reported R224 should not be transferred by staff grabbing her orthotic). In an interview on [DATE] at 4:16 PM, the Director of Nursing (DON) reported the nurses, and the managers are to follow up on labs and diagnostics results for the residents. Resident #6 (R6) Review of a Face Sheet revealed R6 admitted to the facility on [DATE]. Review of the MDS dated [DATE] for R6 revealed she had a stage II pressure ulcer upon admission. Review of the Order Summary Report for R6 revealed orders for Right buttocks- cleanse with NS (normal saline), Pat dry, apply zinc, and cover with optifoam every day shift for treatment. During an observation and an interview on [DATE] at 11:43 AM, R6 was lying in bed with a wound vac connected to a surgical wound in her groin. She reported she was admitted to the facility from the hospital after a procedure that required a wound vac in her groin. She had a wound vac at the hospital but could not come to the facility with it because it belonged to the hospital. R6 reported it took a few days after admission to the facility for her to get a wound vac and now has an infection in the wound which requires antibiotics. Review of an admission Skin Assessment for R6 dated [DATE] revealed R6 had a surgical incision in her groin that measured 5.5 cm (centimeters) x 5cm x 4.5cm and a stage II pressure ulcer on her left buttock that measured 1cm x 1 cm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Physician Progress note for R6 dated [DATE] revealed: . Patient did not arrive with wound vac dressing in place. The wound is being treated with wet to dry dressings until wound vac is available. There are no pain issues. Plan: Wound right Groin secondary to hematoma evacuation 9x5c3 cm (sic) Continue with current dressings until wound Vac is available. (Measurements differ than admission nursing progress note.) No mention of a stage II pressure ulcer. Review of the May Medication Administration Record/Treatment Administration Record (MAR/TAR) for R6 revealed the following: 1. Right groin wound-Cleanse with NS (normal saline), pat dry and apply dry gauze and cover with foam dressing until wound vac supplies are available PER [Physician] (NO ISLAND DRESSING) every day shift for treatment, start [DATE] and discontinued [DATE]. 2. APPLY WOUND VAC- To right groin When supplies arrive (Supplies expected to arrive [DATE]) Order can be discontinued and New wound vac orders created when wound vac is applied. May also d/c (discontinue) dry dressing order, every shift for treatment, start [DATE] and discontinue [DATE]. Review of a Nursing Progress note dated [DATE] at 9:58 AM for R6 revealed: . Right groin wound with foam border dressing in place until wound VAC supplies arrive, these have not yet. Complaining of increased pain and Tylenol is not adequate. Review of a Nursing Skin/Wound Note dated [DATE] at 11:35 AM for R6 revealed: Wound bed pink with yellowish areas, foul odor noted. 6 cm wide x 4 cm length x 3.9 cm deep. Surrounding skin/tissue ecchymotic (sic), fissures extending laterally and medially along abdominal fold line. Wound VAC applied to area with bridging foam to open fissures. [Physician] here and updated of VAC placement. No indication the physician was aware of or notified of the abnormal wound assessment described above other than he was notified the wound vac was in place. No indication of where or what wound this is described. Review of a Late Entry Nursing Skin/Wound Note for R6 dated [DATE] revealed: Left medial buttock wound 2.1 x 1.1 cm x 0.2 cm. Wound bed pink. Surrounding area reddened, intact. Blanchable. Island dressing applied (no foam border dressing available at this time.) Will replace when restocked. Review of an IDT (interdisciplinary) Note for R6 dated [DATE] revealed: . has a wound vac for incision to groin and a stage II buttocks to wound (sic). Review of a Nursing Skin Assessment dated [DATE] for R6 revealed her skin was not intact and no assessment of her surgical wound in the groin was documented: Treatment continues to right buttock, area appears to be slowly improving. No other new areas of concern identified. This document did not reference a skin assessment was documented anywhere else. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nursing Progress note dated [DATE] for R6 revealed: Called to resident's room d/t possible wound VAC leaking. She states, I can smell it, and I haven't been able to. Assessed dressing. Drainage noted at bottom of dressing at fold next to groin. Foul odor noted coming from dressing. You can hear an air leak at the same site. Dressing changed and treatment resumed. No indication the physician was notified of foul odor or wound assessment. (5 days after the first documented abnormal assessment.) Review of a Nursing Progress note Skin/Wound Note dated [DATE] at 1:17 PM for R6 revealed: 5cm x 5 cm x 4 cm right groin wound with foul smelling odor. Beefy red wound base. Bleeding noted to wound rim and inferior left aspect when old foam removed. Fissures extending laterally from each side of wound along abdominal fold line. Pain with dressing changes described as burning. Also, resident indicates pain to lateral aspect near hip where bruising is noted from hematoma. Wound VAC dressing reapplied. Physician aware of ongoing treatment. No indication the physician is aware of the condition of the wound. Review of a Nursing Progress Note for R6 dated [DATE] revealed: Wound vac placed on hold per physician at this time d/t (due to) bedside debridement, wound care provided per updated order. See skin note for updated measurement per physician. Review of a Skin Assessment dated [DATE] for R6 revealed her skin was not intact. Groin- Wound vac reinforced today. Coccyx- Continued treatment orders. No new skin issued noted. Review of a Nursing Progress note dated [DATE] revealed: Wound VAC replaced today at bedside by physician per new order. Physician ordered IV Ancef 2 G every 8 hours x 7 days d/t (due to) the foul odor and necrotic tissue he debrided at the bedside. Review of a Physician Note dated [DATE] for R6 revealed: Seen for examination of wound and reapplication of Wound Vac dressing. The foul smell has now subsided. Currently on IV antibiotics. Exam: Inspection Right Hi wound- There (sic) is no / minimal necrotic tissue. Wound floor has healthy tissue. No mention of a stage II pressure ulcer. Review of an IDT (interdisciplinary) Note for R6 dated [DATE] revealed: . She has a wound vac for stage II pressure ulcer on buttocks and is receiving IV (intravenous) therapy for wound infection. This did not address the surgical wound in in her groin. Review of an Order Summary for R6 revealed on [DATE] an order for 2 Grams (GM) of cefazolin (antibiotic) is to be given every 8 hours intravenously for wound healing. No cultures documented in the EMR. On [DATE] Doxycline Hyclate (antibiotic) ordered twice a day for bacterial infection in the groin wound for 2 weeks. On [DATE] fluconazole (antifungal), 200 mg (milligrams) ordered for 13 days. On [DATE] Amoxicillin-Pot clavulanate (antibiotic) 875-125 mg ordered for bacterial infection/Groin wound for 2 weeks. No orders for labs or wound cultures. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Skin Assessment dated [DATE] for R6 revealed her skin was intact and No new issues. Right thigh dermatitis almost resolved. Review of the Care Plan for R6 revealed the following: Focus: Alteration in skin integrity related to Pressure injury to left buttock, initiated [DATE], Interventions: Assess/evaluate impaired area weekly and document per protocol. During an observation and an interview on [DATE] at 2:31 PM, R6 was in bed and reported her brief was soaked. R6 reported she is on Lasix (diuretic) and cannot always tell when she urinates and will be wet for long periods of time. CNA V entered the room and provided incontinence care at this time. R6's buttocks were observed to have a darker purple area the size of a tennis ball in the cleft of her buttocks with some maceration and blanchable skin throughout. No dressing in place per orders for Treatment and no signs of a pressure ulcer observed. R6 said it is better than it used to be. CNA V then applied a barrier cream with a new brief. Review of the June Medication Administration Record/Treatment Administration Record (MAR/TAR) for R6 revealed on [DATE] she did not receive a dressing change on her left buttocks as ordered and is documented as receiving dressing changes on [DATE] and [DATE], even though there was no dressing in place during the observation on [DATE]. A request for a policy for skin assessments was made and the facility provided a document dated 2019 with the name of another entity at the bottom of the form titled Wound Assessment and Monitoring from the Wound Prevention and Management Guidebook revealed: . Assess the wound initially and re-assess at least weekly to monitor progress toward healing. In an interview on [DATE] at 4:16 PM, the Director of Nursing (DON) reported she was not working here when R6 admitted to the facility, but did help facilitate getting R6's wound vac after her admission to the facility. The DON reported it was an Admissions thing and did not have a back up of supplies at the facility. The DON confirmed there were no cultures in the EMR for R6's surgical wound and will look to see if any were done. No cultures were provided by the end of this survey. In an interview on [DATE] at 4:25 PM, Clinical Nurse Consultant (CNC) U reported they do not have formal policies for admissions, transfers and discharges and they just follow the standards of practice. The nurses perform weekly skin assessments here but do not have a policy for it. There are no policies for documenting or maintaining medical records. CNC U then reported the standards of practice should be followed for documentation and there should be an order for discharges.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a fall for 1 of 2 residents reviewed (R1) for falls, resulting in R1 sustaining multiple rib fractures and a hip fracture. Findings include: A review of R1's admission Record, dated 6/12/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R1's admission Record revealed they had multiple diagnoses that included cerebral palsy, epilepsy, abnormal posture, torticollis (a rare condition in which the neck muscles contract causing the head to twist to one side), and scoliosis. A review of R1's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/14/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 12 which revealed R1 was moderately cognitively intact. During an interview on 06/12/25 at 09:50 AM, R1 stated through short statements and yes/no answers that in February 2025 she rolled out of bed while staff were doing a bed bath. She stated staff rolled her to the side and she kept going until she was on the floor. R1 stated one staff member was present and giving her the bed bath. She stated usually only one staff member provides care to her, including bed baths. R1 denied the facility uses two staff members for her care. R1 stated after she fell out of bed onto the floor she had difficulty breathing and pain. She stated staff called an ambulance and staff stayed with her until the ambulance arrived. R1 stated she had several fractured ribs and a hip fracture. She stated she was in the hospital for several days, but did not have surgery. A review of R1's Fall Risk Assessment, dated 12/10/24, revealed R1 scored a 15 (Moderate Risk). A review of R1's Activities of Daily Living (ADL) Care Plan, dated 9/28/20 and revised on 12/27/23, revealed R1 required 2 staff participation for repositioning and turning in bed (date initiated: 4/6/23). However, R1 only needed total assistance of one person with brief changes and using the bed pan per the care plan. A review of R1's Nurse's Notes, dated 2/7/25, revealed, Resident observed laying on her left side on the floor next to the bed. Resident moaning with a snort like breathing. Resident complained of pain to back. Resident assessed, large forming bump noted on back of head. Hump in the middle of the bed observed Resident sent out to the emergency room for evaluation and treatment. Resident assessed . A review of the hospital's Internal Medicine Daily Inpatient Progress Note, dated 2/17/25, revealed on 2/7/25 R1 was admitted to the hospital due to rib fractures and a hip fracture after a fall. She presented to the ER (emergency room) after falling out of bed while receiving a bath at her facility. Workup revealed multiple rib fractures as well as a hip fracture. Additionally she was found to have a new LLL (left lower lobe) subsegmental PE (pulmonary embolism- a blood clot in the lung) and a very small left-sided pneumothorax (a condition that can be caused by a blunt or penetrating injury (e.g., from fractured ribs) where air leaks into the space between the lung and chest wall and causes the lung(s) to collapse) . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of R1's hospital Discharge Summary, dated 2/17/25, revealed R1 had been seen in the emergency department after a fall from her bed at the facility while staff was giving her a bed bath. R1 fell approximately 3' (three feet) from the bed while staff where mobilizing her. R1 had pain in the chest wall. It was discovered at the hospital that she had sustained several rib fractures and a hip fracture. A review of Certified Nursing Assistant (CNA) D's typed statement, undated, revealed she was cleaning R1 up because R1 had a bowel movement. She rolled R1 onto her right side to clean her up. CNA D stated she needed more washcloths, so she turned around to grab some more washcloths. She stated when she turned back around, she heard R1 make a grunting/growling noise and R1 was rolling off the bed. CNA D stated she could not catch her in time before she rolled off the bed completely. CNA D stated she had checked R1's kardex (a summary of a resident's care needs) before providing care and she noticed R1 was one assist for toileting and two assist for transfers. CNA D stated she did not remember if she checked R1's bed mobility assistance on the kardex. She then expressed guilt/remorse that the incident occurred. A review of Licensed Practical Nurse (LPN) J's typed interview, undated, revealed she was told by CNA T that she needed to go to R1's room. LPN J stated when she arrived she saw R1 lying on her left side on floor on the right side of the bed. Staff had placed a pillow under her head. R1 was moaning with snort like breathing. LPN J stated she saw loose stools on the floor. LPN J stated she palpated R1's body and R1 stated she had pain on her back and left leg. LPN J stated she observed a goose egg on the back of R1's head. LPN J stated she only noticed a lump in the mattress when the former Director of Nursing (DON K told her there was a lump there. A review of CNA D's personnel file revealed she had a Final Written Warning Corrective Action Notice for an infraction on 2/7/25 (R1's fall during care?). She was written up for a Failure to follow policies, procedures, or regulations. However, there was not any additional information in the written warning that would elaborate of what those policies, procedures, or regulations were or what exactly CNA D failed to do. A review of CNA D's personnel file revealed she also had received a certificate of completion, dated 2/28/25, for Safe Resident Handling and Movement. During a second interview on 06/13/25 at 01:25 PM, the NHA stated CNA D had to complete training on safe resident handling because she rolled her (R1) away from her. The NHA stated if CNA D would have rolled her (R1) towards herself (CNA D), she would have caught her and R1 would not have rolled off the bed. The NHA further stated if there had been a hump/lump in the mattress staff should roll the resident over it and have another staff member on the other side of the mattress to make sure the resident did not roll off the bed. The NHA also stated she did not know what specifically CNA D received her final written warning for, but she can only assume it was because CNA D did not take proper precautions to prevent R1 from falling off the bed during care on 2/7/25.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure that one resident (R224) of two residents reviewed for bowel and bladder, who admitted to the facility continent of bowel and bladder, received timely assistance to maintain continence. Findings include: Resident #224 (R224) Review of a Face Sheet revealed R224 admitted to the facility on [DATE] with pertinent diagnoses of fusion lumbar spine, urinary tract infection (UTI), and fractured lumbosacral spine and pelvis. Review of the Minimum Data Set (MDS) dated [DATE] for R224 revealed she was always continent of bowel and bladder. R224 required substantial/maximal assistance for toilet transfers. Review of the Care Plan for R224 revealed: Focus: I have indwelling catheter, initiated on 5/30/25 and revised on 6/2/25 by the MDS Coordinator. The MDS reflects R224 is continent. Focus: At risk for infection related to indwelling catheter, initiated on 6/2/25. Focus: . ADL (activities of daily living) . Interventions: . TOILET USE: I require 1 staff participation to use toilet, initiated 5/30/25. During an observation and an interview on 6/10/25 at 3:10 PM, R224 reported she was on antibiotics prior to admission for a urinary tract infection (UTI) and was on antibiotics that were not available upon admission to the facility. R224 reported she has had to wait for long periods of time for the call lights to be answered so she can get assistance with toileting. The longest time she waited for the call light to be answered was about an hour and soiled her pants because she could not wait that long. A couple staff at night will tell her to just go in her brief if she cannot hold it and not to worry about it. If you have to go, just go they told her. R224 reported it makes her feel bad when she urinates inside her brief even though the staff are very kind about it and will clean her up. R224 did not have an indwelling catheter. Review of the Call Light logs for R224 from 6/5/25 to 6/12/25 revealed the following call wait times: 6/5/25 at 6:28 AM, 27:14 minutes 6/5/25 at 7:48 AM, 40:31 minutes 6/5/25 at 12:23 PM, 24:22 minutes 6/5/25 at 8:01 PM, 20:40 minutes 6/6/25 at 7:58 AM, 40:37 minutes 6/6/25 at 9:30 AM, 22:33 minutes (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/6/25 at 1:48 PM, 30:01 minutes 6/8/25 at 9:10 PM, 36:17 minutes 6/9/25 at 7:31 PM, 23:06 minutes 6/10/25 at 11:14 AM, 41:46 minutes 6/11/25 at 5:16 AM, 35:17 minutes 6/11/25 at 6:06 AM, 2:19 minutes 6/11/25 at 7:55 AM, 45:49 minutes Review of the Nursing Progress notes dated 6/2/25 at 12:36 PM for R224 revealed: Urine culture results received . new orders received for . Bactrim DS (double strength) BID (twice a day) x 7 days. Review of the Urinary continence task list revealed R224 dated 6/1/25 to 6/10/25 revealed the resident had four incontinence episodes and on 5 days she was documented as toileted once a day. One example was on 6/7 when R224 was assisted toileting at 1:10 AM and again at 9:10 AM. There was no documentation to show R224 was toileted until 2:02 AM the next morning. In an interview on 6/11/25 at 4:35 PM, Certified Nursing Assistant (CNA) S reported staff are to document in the EMR each time a resident is toileted. CNA S reported she is aware of R224's concerns about long call light wait times. CNA S is aware of the 3rd shift staff not taking R224 to the bathroom and giving her a bed pan instead. CNA S reported she knows that is not how it is supposed to be. CNA S reported she told the DON of R224's concerns, and the DON did meet with the resident. A request for concern forms for R224 on 6/11/25 at 11:56 AM was made via email and the Nursing Home Administrator (NHA) responded that the resident did not have any concern forms. In an interview on 6/13/25 at 10:41 AM, the Director of Nursing (DON) reported she had been addressing call light times in daily meetings. The audits she had done so far were not problematic. The DON reported it is not the facility's practice to not assist a continent resident timely to the bathroom and advise residents to urinate in their brief. A reasonable time for call lights to be answered is about 5-10 minutes. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Urinary tract infections (UTIs) are the fifth most common type of health care-associated infection .Escherichia coli, a bacterium commonly found in the colon, is the most common causative pathogen ([NAME], 2020). The risk for a UTI increases in the presence of .urinary and fecal incontinence, and poor perineal hygiene practices. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1229). Elsevier Health Sciences. Kindle Edition.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that monthly pharmacy review irregularities and pharmacist recommendations were received and addressed by the physician for 2 of 5 residents (R1 and R17) reviewed for monthly pharmacy medication regimen reviews. Findings include: A review of the facility's Medication Regimen Review policy, last revised 6/1/24, revealed, 9. Facility should encourage physician/prescriber or other responsible parties receiving the MRR (Monthly Regimen Review) and the director of nursing to act upon the recommendations contained in the MRR. 9.1 For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained in the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected . 9.2 The attending physician should document in the residents' health (medical) record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. 9.2.1 If the attending physician/prescriber has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record. A review of the facility's Medication Regimen Review policy, last revised 6/1/24, revealed, 11. When the consultant pharmacist identifies a time-sensitive medication related concern during MRR that requires immediate action, the consultant pharmacist will notify the nurse and request the facility contact the attending physician/prescriber to communicate the issue and obtain direction or new orders. 11.1 If the attending physician has not responded by the time the consultant pharmacist has completed his/her consultation for the day, the issue will be escalated to the medical director for immediate action by facility staff . 13. The attending physician/prescriber should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident . R1 A review of R1's admission Record, dated 6/12/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R1's admission Record revealed they had multiple diagnoses that included cerebral palsy, epilepsy, abnormal posture, torticollis (a rare condition in which the neck muscles contract causing the head to twist to one side), and scoliosis. A review of R1's medical record, dated 6/27/24 to 6/12/25, revealed the pharmacist made recommendations on 8/27/24 (Labs), 1/31/25 (Vitamin D), and 4/30/25 (warfarin and feeds). However, the pharmacist's consultation reports for these dates that would detail what the actual recommendations were could not be located in R1's medical record. In addition, the pharmacist's review and/or consultation report for July 2024 was not in R1's medical record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/25 at 12:55 PM, the Nursing Home Administrator (NHA) was notified R1's pharmacy review of July 2024 and consultation reports for 8/27/24, 1/31/25, and 4/30/25 could not be located in R1's medical record. The NHA stated she would try and locate them and would provide copies to the surveyor, if she can locate them. The NHA also stated that if she can locate the pharmacy consultation reports and the physician agreed with the recommendation, then she would provide supporting documentation that the recommendation was implemented. During a second interview on 06/13/25 at 8:50 AM, the NHA stated she could not locate R1's pharmacy recommendations that were signed by the physician (MD C). The NHA stated she contacted the pharmacy yesterday (6/12/25) and they sent copies of unsigned pharmacy consultation reports for 7/29/24, 8/27/24, 1/31/25, and 4/30/25. A review of R1's Consultation Report, dated 7/29/24 and unsigned, revealed the pharmacist recommended that the physician discontinue Vitamin D 3 2000 units daily and change it to Vitamin D 3 50,000 units twice monthly due to frequent dosing increased medication costs and it also placed R1 at increased risk for adverse events (negative side effects). However, the NHA failed to provide documentation that the physician had reviewed and/or addressed this report. A review of R1's Consultation Report, dated 8/27/24 and unsigned, revealed the pharmacist recommended lab monitoring (a CBC, BMP, and Phenobarbital trough concentration) starting on the next lab day and then every six months because R1 had Phenobarbital (a medication for seizures) prescribed. However, the NHA failed to provide documentation that the physician had reviewed and/or addressed this report. A review of R1's Consultation Report, dated 1/31/25 and unsigned, revealed the pharmacist recommended that the physician discontinue Vitamin D 3 2000 units daily and change it to Vitamin D 3 50,000 units twice monthly. This was the same recommendation that the pharmacist made on 7/29/24. However, the NHA failed to provide documentation that the physician had reviewed and/or addressed this report. A review of R1's Consultation Report, dated 4/30/25 and unsigned, revealed the pharmacist made a Clinical Priority Recommendation. Prompt Response Requested recommendation that warfarin (Coumadin- a blood thinner) not be administered with R1's tube feeding formula. The pharmacist recommended administering the warfarin one hour before or two hours after R1's received the formula because of a possible interaction between the formula and the medication (the formula can interfere with the effectiveness of the warfarin due to chemical incompatibilities). However, the NHA failed to provide documentation that the physician had reviewed and/or addressed this report. A second review of R1's medical record, dated 7/29/24 to 6/13/25, failed to reveal any evidence that the physician had reviewed and/or addressed R1's pharmacy recommendations for 7/29/24, 8/27/24, and 1/31/25. However, R1's medical record did reveal a Nurse's Note, dated 5/28/25 (29 days after the recommendation was made), that the nurse spoke to MD C about R1's Coumadin and he discontinued it and started R1 on a different blood thinner. During an interview on 6/13/25 at 9:30 AM, copies of any documentation that the physician had reviewed and/or addressed R1's pharmacy recommendations for 7/29/24, 8/27/24, and 1/31/25 were requested from the Director of Nursing (DON) (2nd request- 1st was to the NHA). In addition, any documentation that the physician had been notified prior to 5/28/25 of the pharmacist's 4/30/25 recommendation regarding R1's Coumadin was requested from the DON. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a second interview on 6/13/25 at 10:10 AM, the DON stated they could not locate any documentation that R1's pharmacy recommendations for 7/29/24, 8/27/24, and 1/31/25 were addressed by the physician. She also stated they could not find any documentation that the physician had been notified prior to 5/28/25 of the pharmacy recommendation on 4/30/25. During a third interview on 6/13/25 at 10:50 AM, the DON stated she found R1's physician signed pharmacy consultation report for 7/29/24. She stated she found it in a soft file binder (not in R1's medical record) in her office that the previous DON had left there. The DON also stated she would continue looking to see if she can locate R1's signed Consultation Reports for 8/27/24 and 1/31/25 and/or documentation that the pharmacist's recommendations were reviewed and/or address by the physician. However, at the time of the completion of the survey and the survey team's exit from the facility, the facility failed to provide documentation that the physician had reviewed and/or addressed R1's pharmacy recommendations for 8/27/24 and 1/31/25. A review of R1's Consultation Report, dated 7/29/24 and signed by the physician on 8/1/24, revealed the physician accepted the recommendation to change R1's Vitamin D 3 2000 units per day to Vitamin D 3 50000 units twice monthly. A review of R1's Medication Administration Records (MAR's), dated 8/1/24 to 6/13/25, revealed R1's Vitamin D 3 (cholecalciferol) was never changed per the pharmacy recommendation on 7/29/24 and provider approval on 8/1/24. Therefore, R1 had received Vitamin D 3 2000 units daily, instead of Vitamin D 3 50,000 units twice monthly, for over ten months after the physician agreed to change the dosing. R17 #1 of 2 Review of the admission Record reflected R17 originally admitted to the facility 1/18/17 with pertinent diagnoses that included Gastro-Esophageal Reflux Disease (GERD). Review of the EMR for R17 reflected a pharmacy Medication Regimen Review (MRR) was conducted 10/29/24 and a recommendation report had been submitted to the facility for physician review. The pharmacy recommendation reflected Please consider 1. Taper omeprazole to 20 milligrams (mg) (orally every other day) x (for) 7 days then Trial DC (discontinue). The EMR did not reveal the recommendation report had been reviewed and responded to by the physician. On 6/12/25 at 5:13 PM an email request was sent to the Nursing Home Administrator (NHA) requesting the Pharmacy recommendation response. On 6/13/25 at 2:56 PM the MRR recommendation of 10/29/24 reflected a response signed and dated 11/28/24 that I accept the recommendation above, please implement as written. Review of the EMR Doctor's Orders Summary for R17 reflected the accepted pharmacy recommendation had not been implemented and R17 had received the Omeprazole daily since the start date of 4/22/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/13/25 at 3:09 PM the NHA and the Director of Nursing (DON) were asked to review the MRR recommendation of 10/29/24. At 3:20 PM the DON reported that the facility did not implement as written as directed by the physician and acknowledged R17 continued to receive the medication. #2 of 2 Review of the EMR for R17 reflected a pharmacy Medication Regimen Review (MRR) was conducted 4/30/25 and a recommendation report had been submitted to the facility for physician review. The pharmacy recommendation reflected BMP (basic metabolic panel) on the next lab day . The EMR did not reveal the recommendation report had been reviewed and responded to by the physician. On 6/12/25 at 5:13 PM an email request was sent to the Nursing Home Administrator (NHA) which asked for the physician response to the pharmacy recommendation of 4/30/25. On 6/13/25 at 3:20 PM the facility provided the response to the pharmacy recommendation of 4/30/25 not found in the EMR. The response reflected it has been signed by a Unit Manager on 5/8/25 but six days later, on 5/14/25, the physician had signed as I accept the recommendation(s), please implement as written. At the bottom of the page was an unsigned and undated note that the lab had been completed on 2/5/25. No documentation was found in the EMR that indicated the physician had noted this lab result from 3 months prior or if it was acceptable to negate the instruction of 5/14/25 to implement as written. On 6/13/25 at 3:23 PM an interview was conducted with MDS RN U who reported she did not know if the Dr. was aware of the lab 2/5/25. As of survey exit no additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled in 1 of 3 medication carts (Yellow Neighborhood Medication Cart) and 1 of 2 medication rooms (Yellow Neighborhood Medication Room) inspected, potentially affecting 25 of 74 facility residents. Findings Include: During an observation on 06/12/25 at 11:10 AM, the Yellow Neighborhood Medication Cart was inspected Licensed Practical Nurse (LPN) F. The following observation and interview were made: - A box of Ketotifen fumarate ophthalmic solution labeled [Resident # 52's last name] 2-10-25 [R52's room number] was observed in the medication cart. However, the solution bottle in the box was not labeled with any information that would identify the resident who the bottle belonged to should it become separated from the box. Other single user bottles/vials in other boxes in the medication cart were all labeled with resident names and/or room numbers. - LPN F stated she did not know if the vials and/or bottles in boxes that were for single resident user should be labeled with their names or other information to identify who the medications belonged to or if it was acceptable to just label the outside boxes. During an observation on 06/12/25 at 03:15 PM, the Yellow Neighborhood Medication Room was inspected with Clinical Care Coordinator (CCC) E. The following observation and interview were made: - A box of Tuberculin Purified Protein Derivative (TB PPD) solution 5 TU/0.1 ml (5 tuberculin units per 0.1 milliliters) was labeled 6-5-25 (open date). However, the vial inside the box was not labeled with an open date. - CCC E stated she was not sure if vials or bottles in boxes in the medication carts should be labeled with resident names if they are single user medications. She stated they are definitely labeled if they are inhalers in boxes because that goes into the resident's mouth. - CCC E also stated, I don't label the TB vials [with the open date]. That could cause confusion, especially if the date on the vial inside the box is different than the date on the box. I only label the TB vial box. The surveyor asked CCC E if there were two open TB vial boxes and the vials were not labeled, how would she know which box the vial goes to if they fall out of their individual boxes and the dates on the boxes are different. She stated, That's a good question. I'll have to find out and get back to you. During a second interview on 06/12/25 at 03:45 PM, CCC E stated, You learn something new every day. She stated she found out that the individual TB vials should be labeled with an open date in addition to the box being labeled. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/25 at 04:00 PM, Registered Nurse (RN) B stated the vials/bottles in boxes in the medication carts should be labeled with the residents' names in case they get separated from the boxes. She also stated that TB vials in the medication rooms should also be labeled with the open date in case they become separated from the boxes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 complete and accurate medical records for 1 of 19 sampled residents (R1). Findings include: R1 A review of R1's admission Record, dated 6/12/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R1's admission Record revealed they had multiple diagnoses that included cerebral palsy, epilepsy, abnormal posture, torticollis (a rare condition in which the neck muscles contract causing the head to twist to one side), and scoliosis. During an interview on 06/12/25 at 09:50 AM, R1 stated through short statements and yes/no answers that in February 2025 she rolled out of bed while staff were doing a bed bath. She stated staff rolled her to the side and she kept going until she was on the floor. R1 stated one staff member was present and giving her the bed bath. She stated usually only one staff member provides care to her, including bed baths. R1 denied the facility uses two staff members for her care. R1 stated after she fell out of bed onto the floor she had difficulty breathing. She also stated she had pain. She stated staff called an ambulance and staff stayed with her until the ambulance arrived. R1 stated she had several fractured ribs and a hip fracture. She stated she was in the hospital for several days, but did not have surgery. A review of R1's Nurse's Notes, dated 2/7/25, revealed, Resident observed laying on her left side on the floor next to the bed. Resident moaning with a snort like breathing. Resident complained of pain to back. Resident assessed, large forming bump noted on back of head. Hump in the middle of the bed observed Resident sent out to the emergency room for evaluation and treatment. Resident assessed . A review of R1's medical record, dated 2/1/25 to 6/11/25, failed to reveal any additional documentation related to R1's fall on 2/7/25 (e.g., neurological checks (if performed), facility transfer forms to the hospital). A review of Certified Nursing Assistant (CNA) D's typed statement, undated, revealed she was cleaning R1 up because R1 had a bowel movement. She rolled R1 onto her right side to clean her up. CNA D stated she needed more washcloths, so she turned around to grab some more washcloths. She stated when she turned back around, she heard R1 make a grunting/growling noise and R1 was rolling off the bed. CNA D stated she could not catch her in time before she rolled off the bed completely. Based on this interview, the Nurse's Note, dated 2/7/25, was inaccurate since it was written to imply that R1 was found on the floor by staff (an unwitnessed fall) instead of accurately reflecting that R1 was allowed to roll out of bed in staff's presence. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/25 at 9:40 AM, the Nursing Home Administrator (NHA) was informed that documentation related to R1's fall on 2/7/25 (e.g., neurological checks (if performed), facility to hospital transfer form) could not be located in R1's medical record. The NHA stated the facility does complete a transfer form when they send someone to the hospital and it should be in the resident's medical record under the Miscellaneous tab. R1's hospital transfer form (the form the facility completes when they send a resident to the emergency room) and neurological checks (if performed), and any other documentation related to R1's fall and hospitalization on 2/7/25 that may be missing from R1's medical record were requested from the NHA. On 6/12/25 at 11:30 AM, the facility provided copies of R1's neurological checks, hospital physician notes, and hospital summary of stay notes. However, the facility failed to provide R1's 2/7/25 facility to hospital transfer form. During a second interview on 6/12/25 at 2:00 PM, R1's facility to hospital transfer form for 2/7/25 was requested from the NHA (2nd request). The NHA also verified that R1's neurological checks and some of the hospital physician notes had not been in R1's medical record. The NHA stated they were in medical records waiting to get scanned into R1's medical record or she had obtained copies from the hospital computer records system. As of the time of the completion of the survey and the survey team's exit from the facility, the facility failed to provide a copy of R1's facility to hospital transfer form for 2/7/25. During an interview on 6/13/25 at 4:38 PM, Regional Admissions Coordinator (RAC) S stated when a resident is sent to the ER, the transfer form would be uploaded under the Misc (miscellaneous) tab under the subheading admission Record and Consent Forms (older transfer forms were located under the Other subheading). She stated it will be labeled ST (State) of [name of State] Facility Initiated Transfer with the date of the transfer. She stated this file would contain the notification to the State of the transfer and the forms they send with the resident to the hospital. A second review of R1's medical record, dated 2/1/25 to 6/13/25, revealed R1's General Surgery hospital notes, dated 2/7/25, were uploaded to R1's medical record on 6/12/25 (4 months after R1's hospital stay) and R1's neurological assessment, dated 2/7/25 was uploaded into R1's medical record on 6/11/25 (4 months after her fall). However, R1's facility to hospital transfer form was not in R1's medical record.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility's Quality Assessment and Performance Improvement (QAPI) committee failed to identify and address issues and develop/implement appropriate plans of action in regard to 1) call light response time and care, 2) Grievances 3) MDS (minimum data set) late submissions and incorrect coding 4) antibiotic stewardship and infection control, 5) complete and accurate medical records, 6) available/updated policies and procedures annually reviewed, 7) and monitor nursing staff for compliance with nursing standards of practice. This deficient practice has the potential to affect all 74 residents who reside at the facility. Findings include: During an interview on 6/13/24 at 11:47 AM, The Nursing Home Administrator (NHA) was asked about her QAPI program and reported they have monthly QA meetings and are all learning together. The NHA reported she had access to the MDS (Minimum Data Set) Quality indicator report and will discuss them with the team. The NHA reported the report did not make sense when she first started a few months ago because it was not accurately reflecting the residents. The past Director of Nursing was not documenting things correctly and made the quality indicators look better than what they were. The NHA acknowledged the facility was just previously cited for infection control and complete and accurate medical records and aware we still had concerns about these issues and as follows: Call lights- When questioned about the concerns of call light response times and the needs of the residents being met per interviews of residents and review of call light timing data, and resident council minute concerns for 4/24/25 and 5/29/25 regarding call light timing and being turned off before the resident needs are met, the NHA reported this concern was identified and no ad hoc meeting was done yet. The NHA reported she gave this task to the Admissions person to have ownership, but they did not make it to the meeting and no follow up was done. Grievances- The NHA reported the Activities Director is supposed to bring resident grievances from the Resident Council Meetings to the IDT (interdisciplinary team) meetings. The NHA reported she reviewed the Resident Council Meeting minutes 6/12/25 (the day before this interview) and told the Activities Director she needed to add the resident grievances to the book and get them all onto forms. The NHA reported her Resident Council minutes were terrible, but she was a great activities person. The NHA reported once any grievance is addressed and completed by the designated department, she will get a copy of it to show it was completed. MDS (Minimum Data Set) late submissions- The NHA reported they were just starting a new admissions process and the MDS staff are involved but it is still in its planning stage. Did not address the late submissions. The NHA was informed of incorrect MDS coding at this time. Antibiotic Stewardship- The NHA reported the Infection Control Preventionist did not compare the Infection Control Pathway to the facility policy. The NHA reported she reached out to Corporate to help educate her more. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Medical records- When queried about skin assessments not in an orderly manner, the NHA reported their current system is a definite improvement. They acknowledged a need for a Performance Improvement Plan (PIP) on 3/4/25 when the concern was identified and started the PIP in April. The NHA reported the Blue Unit is difficult to manage because of the rehab admissions and discharge turnover but they just got a new manager. The NHA reported they identified back in April about the Certified Nursing Assistants (CNA's) not having access to chart their tasks and corrected that by May. The NHA was informed that the CNA's were still not documenting appropriately in the EMR. Regarding the Pharmacy Medication Review, Consultation notes, Practitioner notes, laboratory/diagnostic records, and complete and accurate medical records to reflect the residents care lacking in the EMR, the NHA reported she talked to the staff and felt everyone was just focusing on the skin assessments. The NHA acknowledged some things would get uploaded to the EMR before the doctors and nurses could review them and nursing is now taking longer to get information into the medical records. There were several policies and procedures either not available, from the previous owners, not updated or annually reviewed by the facility as follows: Admissions, transfers and discharges. Infection Control Incontinence Care/Bowel and Bladder Care Skin/Wound Management Antibiotic Stewardship Water Management policy was from the previous owners and last reviewed 7/6/2020. Falls Management policy last reviewed/revised August 2021. Oxygen Administration policy last reviewed 1/2023. Care Plans- Form provided but does not indicate a policy and procedure. MDS policy dated 12/11/2015. The NHA did not have an answer to the lack of policies and procedures and reported they will sometimes use the same ones the hospital has. The QAPI Plan and Policy was requested during the entrance conference. The facility provided a blank plan and no additional details during the discussion of the concerns during the interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235373	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Lodge Trinity Health	18525 Woodland Ridge Drive Spring Lake, MI 49456

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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 have the required attendance of a Medical Director, or a designated physician at the facility's Quality Assessment/Improvement (QAPI) meetings at least quarterly resulting in the potential for lack of oversight of the quality assurance process and coordination of medical care that could impact 74 of 74 residents residing within the facility. Findings include: Review of the QAPI monthly sign in sheets from 6/2024 to 6/2025 revealed the Medical Director or designated physician was in attendance on 6/12/24, 8/5/24, and 4/9/25. This leaves 8 months with no physician representation for the QAPI meetings. In an interview on 6/13/25 at 3:25 PM, the Nursing Home Administrator (NHA) reported the facility has monthly QAPI meetings and has not had their meeting for June 2025 yet. The NHA did not have an answer to why there was no Medical Director present at least quarterly to the meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has two Deficient Practice Statements (DPS) DPS #1 Based on interview and record review, the facility failed to ensure an annual review was completed of the Infection Control policy and procedures to verify adherence to current national standards of care. Findings: Review of the Infection Control Policy and program provided by the facility did not reflect if or when a review had been conducted to ensure the policy and program met current standards of care. On 6/11/25 at 1:04 PM. during the Infection Control task, an interview was conducted with Infection Preventionist (IP) L. IP L was asked to provide documentation the facility Infection Prevention policy and program was reviewed annually. IP L indicated this information would be provided. On 6/13/25 at 9:54 AM an interview was conducted with the Director of Nursing (DON). The DON was informed that the Infection Control policy provided by the facility did not indicate when the policy had been implemented or reviewed. The DON was informed IP L had yet to provide verification of an annual review. The DON indicated this data is usually documented on the first page of the policy but if this review verification was available, it would be provided by survey exit. As of survey exit no documentation was provided by the facility that verified an annual review of the Infection Control policy had been conducted. DPS #2 Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include: During an interview with Environmental Services Director (ESD) [NAME], at 12:54 PM on 06/11/25, it was found that an annual review of the Water Management Plan had not taken place. Further interview found that ESD was unsure of the current members of the interdisciplinary water management team or when the last review of the water management plan had taken place. A record review of the facility policy entitled Water Management Policy Version 7.0 last reviewed [DATE], was found to be developed and maintained by the previous owners with no updated policy for the facility currently owned and operated under [NAME] Health Senior Communities.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to formulate and implement an effective antibiotic stewardship program with written protocols for antibiotic use, documentation, and a monitoring system to provide feedback and ensure adherence to the antibiotic stewardship program. Findings: Review of the undated Infection Control policy provided by the facility contained a section titled Antibiotic Stewardship. This section included information on what components may be included as part of an antibiotic stewardship program. However, the description of the facility's program did not consist of written antibiotic use protocols, a protocol when a resident is admitted to the facility while on antibiotic therapy, necessary documentation surrounding antibiotic use, or include a description of a system to provide feedback to the prescribing medical practitioner. On 6/11/25 at 1:04 PM an interview and record review were conducted with Infection Preventionist (IP) L. IP L described a process identifying an infection through signs and symptoms, initial treatment measures and reporting to the medical provider. IP L reported obtaining labs, lab results and why and when antibiotic therapy would be initiated. IP L reported if antibiotic therapy was to be imitated prior to having laboratory results both nursing and the medical provider would document in the medical record. R26 Review of the Electronic Medical Record (EMR) reflected R26 admitted to the facility 5/19/25 with diagnoses that included a fracture and a history of repeated falls. The medical record reflected R26 had a urinary catheter that had been inserted during admission. Review of the EMR Progress Notes for R26 reflected a Nurses Note dated 6/2/25 at 5:42 PM of urine with increased cloudiness, sediment . and foul smelling. The entry reflected a lab specimen was obtained and transported to the lab for testing. Review of the laboratory urinalysis report dated 6/2/25 reflected an elevated white blood cell count (one of the signs of an infection). The EMR Progress Notes reflected a Nurses Note dated of 6/3/25 at 12:43 PM that the Lab had been called and the specimen was going to culture. The EMR Progress Note of 6/3/25 at 3:57 PM reflected The system has identified a possible drug allergy for the following order Cephalexin Capsule 500 mg (milligram) (an antibiotic) Give 1 capsule by mouth three times a day for UTI (urinary tract infection) for 7 days. This indicated an order to start an antibiotic had been received but the EMR did not reflect documentation the physician had been notified. The EMR did not reflect any documented justification for the initiation of antibiotic therapy pending culture results. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the EMR Progress Note entry on 6/3/25 at 4:50 PM reflected documentation that This order is outside of the recommended dose or frequency, Macrobid Oral Capsule 100 mg (an antibiotic) give 1 capsule by mouth every morning and at bedtime for UTI for 5 days . This drug's dose should be adjusted based on renal function. Manual screening is required. Review of the EMR did not reveal any documentation to explain the entries of two different antibiotics for UTI or that renal function was considered as part of the antibiotic therapy. Lab results for the urinalysis were identified but no culture results were found in the EMR as of 6/11/25. No documentation was found that indicated the medical provider had been contacted or that the medical provider had commented on the course of treatment. The: Miscellaneous (misc) section of the EMR reflected the last medical provider encounter occurred on 5/30/25 prior to the UTI. The EMR did not reflect a Care Plan for an active UTI or that antibiotic therapy had been initiated. Review of the EMR did not reflect another entry regarding antibiotic therapy from 6/3/25 until 6/6/25. However, on 6/6/25 at 4:45 PM there was a repeat entry that The system has identified a possible drug allergy . to the Cephalexin Oral tablet. Upon request the facility provided a timeline of R2's UTI identification and treatment to clarify information present and not identified in the EMR. IP L provided the following information: (R26) UTI Timeline 6/2/25 Resident voiced concern for UTI. Sediment noted in Foley Catheter with Urine foul odor 6/2/25 UA collected and sent to lab. 6/3/25 UA + (positive) Resident started on Macrobid 100 mg (twice daily) (times) 5 days pending culture results. 6/6/25 UA culture results sent to facility. Culture (positive) for . Physician notified and antibiotic changed to Keflex . End of timeline. On 6/12/25 at 11:35 AM the Nursing Home Administrator (NHA) and IP L were interviewed regarding the Antibiotic Stewardship Program and EMR documentation. The NHA reported the description of the facility Antibiotic Stewardship Program provided was the correct policy. The NHA reported that the physician does not document in the facility EMR. The NHA reported the physician uses a system that does not communicate with the facility EMR. IP L also acknowledged the physician does not document in the facility EMR and reported a request was submitted to the physician for the notes on R26. As of survey exit neither the NHA nor IP L provided any additional information that indicated the antibiotic therapy provided R26 was consistent with an antibiotic stewardship program.