STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235380	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Rose City	517 West Page Street Rose City, MI 48654

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings includeOn 04/20/2026 at 9:12am during the initial kitchen tour with Certified Dietary Manager (CDM) P, observed chopped tomatoes without datemarking in the two-door refrigerator. During this observation, CDM P was interviewed on when the tomatoes were chopped, and she stated she didn't know. According to the facility's policy on labeling and dating foods, Refrigerated food prepared in the healthcare community is labeled with the date to discard or to use by. This includes leftovers. The discard/use by date will be a maximum of six days after preparation. The day of preparation is counted as Day 1.According to the 2022 Food Code, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.On 04/20/2026 at 9:21am observed calcium buildup on interior walls of ice machine in the kitchen. During this observation, CDM P was interviewed on how often the ice machine is cleaned, and she answered that she wasn't sure, but she thinks it's every month.On 04/20/2026 at 10:09am interview with Maintenance Director Q, and he stated that the ice machine is cleaned every 3 months.Record review of the facility's ice machine cleaning logs found that the task description is listed as Ice Machines: Check filters (if present), clean coils, sanitize interior, delime as necessary and it was marked as completed on 1/31/2026, 10/31/2025, 7/31/2025, 4/30/2025. According to the FDA 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.On 04/20/2026 at 11:57am observed two dirty cups sitting in the basin of handwashing sink, located in the kitchenette. According to the FDA 2022 Food Code, 5-205.11 Using a Handwashing Sink, A handwashing sink shall be maintained so that it is accessible at all times for employee use .A handwashing sink may not be used for purposes other than handwashing .An automatic handwashing facility shall be used in accordance with manufacturer's instructions.On 04/20/2026 at 12:07am during lunch observation, ranch was temped at 44 F and salad made with lettuce, tomato and cheese was temped at 49 F using a thermometer probe. During this observation, CDM P was interviewed on what cold holding temperature should be and she stated 41 F. According to the facility's policy on cold holding, it states Hot foods will be plated at 135 F or higher and cold foods will be plated at 41 F or lower.According to the FDA 2022 Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control, time/temperature control for safety food shall be maintained: .at 5 C (41 F) or less.

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to implement and operationalize a comprehensive Infection Control (IC) program incorporating outcome and process surveillance, comprehensive data collection, tracking of potential infections, analysis, and trend identification resulting in the potential for spread of microorganisms and illness to all 68 facility residents. Findings include:A review of the facility IC program was completed on 4/22/26 at 10:02 AM with Unit Manager IC Registered Nurse (RN) Z. RN Z was asked what one of the most important things that staff can do to prevent infections is and replied, Hand Hygiene. When queried how they monitor to ensure staff are performing hand hygiene appropriately, RN Z indicated observation. When queried if the facility utilized a standardized criteria for infections, IC RN Z responded, McGeer.All facility IC information and surveillance data for November 2025 was requested from RN Z at this time and a review was completed. RN Z provided a line list, mapping tool, and a summary. No process surveillance documentation was provided.The printed infection line list for November 2025 only included residents treated with antimicrobial therapy and did not include carry-over infections from October 2025. The line list did not indicate if the infection meet criteria for treatment with an antimicrobial agent. The line list included 29 infections for 25 residents. The line list did not delineate if the residents with UTIs had indwelling urinary catheters. When queried regarding the line list not indicating if the UTI was associated with an indwelling urinary catheter, RN Z replied, I put that (catheter associated UTIs) on a different sheet. The line list included a total of 5 UTIs with four UTIs being facility acquired. A review of the mapping tool revealed 29 infections including 5 UTIs. When queried how they identified potential spread and/or trends if carry over infections were not included, RN Z revealed they track carry over infections on a separate line list. The carry over infection line list for November 2025 was provided at this time. When asked what the mapping tool is used for, RN Z revealed it is used as a quick visual guide to identify possible infection trends. When queried if carry-over infections from the previous month are able to be spread to others, RN Z indicated they could. RN Z was then asked why carry-over infections were not included on the mapping tool for identification but did not provide an explanation. The IC summary for November 2025 detailed, The facility had 29 residents treated with antibiotics in November. 17 residents were started on antibiotics in-house, 12 were admitted on antibiotics. Of the 17 Facility-initiated antibiotics: UTI - 4 (prevalence 6.25%); Skin - 3 (prevalence 4.68%); Respiratory - 9 (prevalence 14.06%); Other (Shingles) - 1 (prevalence 1.56%). Of the 15 Community-acquired antibiotic; Sepsis (infection causing extreme, exaggerated response throughout the body) - 2; Osteomyelitis (infection of the bone) - 3; Gastritis (inflammation of the stomach lining)- 1; Respiratory - 4; Skin - 1; UTI - 1. When queried regarding the monthly summary document specifying there were 12 residents admitted on antibiotic in one place and 15 in another, RN Z reviewed the information and responded that there were 12 residents admitted on antibiotic therapy and they had made an error. Review of the residents with facility-acquired urinary tract infections (UTI) revealed three of the four infections listed Escherichia coli (bacteria found in intestines and stool) as the causative organism of the UTI. A review of the IC mapping revealed the residents with UTIs caused by Escherichia coli resided in the same wing of the facility. A review of the IC summary for the month specified, Trends. UTIs were slightly up from 3 in October to 4. No new bacteria species identified, No MDROs (Multidrug Resistant Organisms) in urine. The summary did not address Escherichia coli in the urine. RN Z was asked if they identified a trend related to the three residents with UTIs caused by Escherichia coli and responded that the residents did not all reside on the same hall of the facility. When asked if the residents resided on the same wing of the facility, RN Z confirmed they did. When queried if the same staff on that wing worked with the residents in all the halls where the Escherichia coli UTIs were identified, RN Z confirmed they did. When queried if the UTIs were a potential infection trend, RN Z verbalized they were and stated, I don't know how I missed that. With further inquiry, RN Z stated, It was an oversight. When asked how they are able to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	identify and educate to prevent spread of infection when trends are not identified, RN Z verbalized understanding but did not provide further explanation. The line listing identified Resident #29 as having shingles (viral infection), receiving treatment with Bactrim DS (antibiotic), and being placed on contact precautions. The line listing did not specify when the contact precautions were implemented. When queried why the resident was treated with an antibiotic for a viral infection, RN Z indicated that was what the Health Care Provider (HCP) ordered. A review of the IC summary did not include any information explaining the rationale for treatment of a viral infection with an antibiotic (treatment for bacterial infections). RN Z verbalized the HCP diagnosed Resident #29 with shingles from a physical exam, but a laboratory swab diagnostic test was not completed. When queried why Resident #29 was not placed in airborne and contact precautions and if the shingles was disseminated, RN Z responded that it was localized. When queried if the Resident was immunocompromised, RN Z did not respond. RN Z then verbalized they were unaware that shingles infections required airborne precautions. The Centers for Disease Control (CDC) Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions: Guidelines for Isolation Precautions: Appendix A (February 2025) was reviewed with RN Z at this time. RN Z revealed the Resident's shingles lesions were on their leg and able to be covered. RN Z was then asked how they tracked possible infections and/or residents with signs/symptoms of infections who do not receive antimicrobial treatment and stated, We do not track potential infections. When queried how they identify possible infections before they can spread if they do not track potential infections and/or residents with signs/symptoms of infection who are not receiving antimicrobial treatment, RN Z did not provide an explanation. When queried regarding process surveillance such as audits completed for the month of November 2025, RN Z revealed they did not complete any IC audits/process surveillance for November 2025. When asked why no process surveillance was completed, RN Z replied, I don't know what happened. I get pulled to the floor a lot especially on nights. When queried regarding IC education for facility staff pertaining to identified IC concerns, RN Z revealed no IC education was completed for the month related to any identified IC concerns. An interview was conducted with the Director of Nursing (DON) on 4/22/26 at 12:11 PM. When queried if the facility should be tracking potential infections/residents with signs/symptoms of infection as part of the IC program, the DON verbalized they should. The DON was informed of lack of tracking of potential infections, inaccurate data on monthly analysis, lack of process surveillance, lack of infection trend identification for November 2025 and lack of follow-up education to prevent further infections. The DON verbalized understanding of all concerns. No further explanation was provided. Review of facility policy/procedure entitled, Infection Prevention and Control Guideline (Effective: 11/18/17) revealed, Guideline: It is the practice of this facility's Infection Prevention and Control Program (IPCP). to prevent recognize and control the onset and spread of infection. includes a system for preventing, identifying, reporting, investigating, and controlling infections.

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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 implement and operationalize a comprehensive antibiotic stewardship program, incorporating a facility wide system to monitor, track, and ensure accountability for antibiotic use including consistent use and documentation of standardized tools/criteria for antibiotic therapy resulting in the potential for inappropriate antimicrobial use and the development of resistant organisms for all 68 facility residents. Findings include:A review of the facility IC program was completed on 4/22/26 at 10:02 AM with Unit Manager IC Registered Nurse (RN) Z. When queried if the facility utilized standardized criteria for infections, IC RN Z responded, McGeer. All facility IC information and surveillance data for November 2025 was requested and reviewed with RN Z at this time. Documentation provided included a line list, mapping tool, and a summary. The line list for November 2025 did not include if the infection met McGeer criteria for treatment. A review of the November 2025 Summary did not indicate the number of infections which met criteria and did not include any information pertaining to the appropriateness of treatment. When queried regarding the line listing and summary not including whether the infection meet criteria for treatment, RN Z indicated all infections met criteria. With further inquiry, RN Z revealed a McGeer form is completed in the Electronic Medical Record (EMR) for all residents who are started on an antibiotic. RN Z verbalized they do not maintain copies of the form as it is available in the EMR. When queried how they knew and tracked if the infection met McGeer criteria when it was not listed on the line list, RN Z verbalized all infections met criteria. Review of the line list revealed Resident #80 was included on list for two infections. The first infection was listed as a facility acquired Upper Respiratory Infection (URI). Per the line list, the infection onset date was 11/11/25 and they received Azithromycin (antibiotic) from 11/16/25 to 11/20/25. The signs and symptoms of infection were listed as fever but did specify the date of the fever. The second infection for Resident #80 was listed as community acquired gastritis with an onset date of 11/7/25. Per the line list, Resident #80 received Micafungin (anti-fungal medication) from 11/7/25 to 11/18/25. A causative organism was not included on the line list.Upon request, RN Z provided Resident #80's electronic Nursing: McGeer Infection Symptom Tracking form, dated 11/14/25 at 12:04 PM. Review of the form revealed the Resident's signs and symptoms of respiratory infection were observed on 11/14/25 and the Health Care Provider (HCP) was notified that day. Per the documentation on the form, Resident #80 did not meet the criteria for treatment of an upper or lower respiratory infection. When queried regarding the line list specifying the Resident's signs and symptoms of infection starting on 11/11/15 not matching the date listed on the McGeer form, RN Z was unable to provide an explanation. When queried regarding the infection not meeting criteria for treatment, RN Z reviewed Resident #80's documentation and confirmed the infection did not meet criteria. When asked if this was addressed with the HCP, RN Z revealed it was not. Upon request for the McGeer Infection Symptom Tracking form for Resident #80's community acquired gastritis diagnosis, RN Z responded they did not have one. When asked why they did not have a form, RN Z stated, Don't do for residents who are admitted on antimicrobial treatment. When queried how the facility ensures the Resident is receiving the correct treatment if they are not utilizing standardized criteria, RN Z responded that the HCP continues the medications ordered from the hospital. No further explanation was provided. RN Z was asked if they obtain records and cultures from the hospital for residents admitted on antimicrobial therapy and indicated they are able to request the results. Further review of the line list revealed a resident was admitted to the facility with a Urinary Tract Infection and received Zofran (antibiotic) from 11/1/25 to 11/2/25. The line listing specified there was no growth under organism. When asked, RN Z responded that a Nursing: McGeer Infection Symptom Tracking form had not been completed because the Resident was admitted to the facility with the UTI on antibiotic therapy. When queried why the Resident was receiving an antibiotic if their culture and sensitivity showed no growth, RN Z did not provide further explanation. RN Z was asked why the monthly summary did not include an (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	analysis of antibiotic use including appropriateness of antibiotics for all residents receiving antimicrobial treatment and how the facility ensures appropriate treatment to prevent unnecessary or inappropriate antibiotic use, RN Z did not provide an explanation but indicated they will be more in-depth in their analysis. When queried regarding addressing inappropriate antibiotic use with the HCP including in the summary, RN Z indicated the HCP makes the final decision regarding treatment, but they will be addressing concerns with them going forward. An interview was conducted with the Director of Nursing (DON) on 4/22/26 at 12:11 PM. The DON was asked if residents admitted to the facility on antimicrobial treatment should be evaluated for appropriate treatment using a standardized criteria and responded, Yes. The DON was informed that McGeer criteria was not being completed for residents admitted to the facility on an antibiotic. The DON responded that it should be completed for every resident who receives an antibiotic whether or not treatment is initiated in the facility. When queried regarding the monthly summary not addressing resident infections who do not meet criteria for treatment, including Resident #80, the DON verbalized understanding of concerns. Facility policy/procedure related to antibiotic stewardship was requested during the entrance conference on 04/20/26 at 9:08 AM but not received by the conclusion of the survey. Review of facility policy/procedure entitled, Infection Prevention and Control Guideline (Effective: 11/18/17) did not address antibiotic stewardship.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a sanitary environment for 1 of 1 resident reviewed for clean environment (Resident #18) and a safe environment for all residents currently residing in the facility.Findings Include: Resident #18: Review of the resident's Face Sheet, nursing notes dated 2/26 through 4/26, and care plans dated 10/24/23, revealed Resident #18 was 76 years-old, admitted to the facility on [DATE], alert but not able to make own healthcare decisions, dependent on staff for Activities of Daily Living and exhibited extensive behaviors; Fall Risk care plan dated 10/24/23, revealed his mattress was on the floor due to a fall history with behaviors. The resident's diagnoses included, chronic lung disease, adjustment disorder, depression, stroke, and Hemiplegia of the right side. The resident put himself on the floor often and had his mattress kept on the floor due to behaviors and preferences. Observation made on 4/21/26 at 8:00 a.m., revealed a mattress sitting directly on the floor. The resident's floor was noted to be very dirty with dried liquid areas by the door and the head of the bed and several pieces of paper with dirt, debris and scuff marks throughout the room. During an interview on 4/22/26 at 7:40 a.m., Director of Housekeeping A stated They (Housekeeping staff) do clean early in the morning about 6:30 a.m. that hall gets done first. Director of Housekeeping A said the resident's room should be cleaned early in the morning and as needed due to his mattress being on the floor. Review of the facility daily cleaning duties (un-dated) revealed resident's floors were to be cleaned daily. On 04/20/2026 at 9:27am observed a chemical feed downstream of an atmospheric vacuum breaker (AVB) at the utility sink located in the kitchen janitor's closet. On 04/20/2026 at 10:28am observed a chemical feed downstream of an atmospheric vacuum breaker (AVB) at the utility sink located in west nursing station janitor's closet. On 04/20/2026 at 10:32am observed a chemical feed downstream of an atmospheric vacuum breaker (AVB) at the utility sink located in east nursing station janitor's closet. According to the State of Michigan's 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve). According to the State of Michigan's 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the dignity of 4 of 6 residents reviewed for dignity (Residents #5, #26, #45 and #62).Findings Include:Resident #45: On 4/20/26 at 9:46 AM, Resident #45 was observed in their room, lying in bed on their back with their eyes closed. A urinary catheter drainage bag was observed on the left side of the bed, towards the room door. The urinary drainage bag was not contained in a bag and did not have a dignity cover in place. Resident #45's urine was very dark and the color of coke. Record review revealed Resident #45 was admitted to the facility on [DATE] with diagnoses which included left femur fracture, heart failure and respiratory failure. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to total assistance to complete ADLs with the exception of eating and oral care. The MDS further detailed the Resident had an indwelling urinary catheter. Review of Resident#45's EMR revealed a care plan entitled, Foley: Resident requires use of an indwelling catheter r/t (related to) acute urinary retention (Initiated: 3/9/26). The care plan included the intervention, Keep draining bag covered to promote privacy (Initiated: 3/9/26). An interview was completed with the Director of Nursing (DON) on 4/21/26 at 2:22 PM. When queried regarding facility policy/procedure related to urinary catheter drainage bags, the DON stated, Cath drainage bags should be in dignity bags. Review of facility policy/procedure entitled, Quality of Life - Dignity (Revised 12/2016) revealed, Policy . 11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered . Review of the facility Resident Rights policy dated 12/2016, stated Resident's shall be cared for in a manner that promotes quality of life and dignity; and enhances quality of life, dignity, respect and individuality. Review of the facility Call Light policy dated 11/2013, stated When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. Review of the facility Call System policy dated 9/2022, stated Calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. Resident #5: Review of the Face Sheet, nurse's notes dated 2/26 through 4/26, and care plans dated 3/25, revealed Resident #5 was 61 years-old, admitted to the facility on [DATE], alert and able to make own healthcare decisions, and dependent on staff for Activities of Daily Living/ADL's. The residents diagnosis included, low back pain, muscle wasting, muscle weakness, osteomyelitis, sacral wound, urinary catheter in place, adjustment disorder, major depression and chronic kidney disease. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation was done on 4/21/26 at 7:45 a.m., of resident in herbed with her urinary catheter bag within sight of the open door. The residents catheter bag did not have a concealed privacy cover on it; there was approximately 1/4 of the bag full of urine at this time. Also, there was several areas of dried blood on the right upper bottom sheet. During an interview done on 4/21/26 at 7:45 a.m., the resident said the blood was from last night, and stated, I am waiting for them to come and change my sheet, it's just got some blood on it. My IV started bleeding last night. They have to get people up I guess. During an interview done on 4/21/26 at 1:30 p.m., Regional Nurse, RN B stated We need to have a privacy bag (on the residents catheter bag), During an interview done on 4/21/26 at 1:58 p.m., the Director of Nursing stated The catheter should be in a dignity (privacy) bag, that's a problem. Resident #26: Review of the Face Sheet, physician active orders dated 4/26, and nurses notes dated 4/26, revealed Resident #26 was 80 years-old, not able to make own healthcare decisions, admitted to the facility on [DATE], and was dependent on staff for ADL's. The residents diagnosis included, major stroke, chronic lung disease, ulcerative colitis, chronic pancreatitis, respiratory failure, Lupus disease, major depression, heart failure, kidney disease, viral hepatitis and malignant neoplasm of endometrium. During an interview done on 4/21/26 at 7:40 a.m., the resident stated, Sometimes food is cold, I have not asked to have it warmed up, I usually get something that you can eat cold. The resident said she orders cold foods due to foods not being served hot. During the confidential resident Group meeting held on 4/21/26 at 11:00 a.m., 4 of 5 resident attendees said the facility served them cold food; they said they did not want to get anyone in trouble so they did not complain. Review of the facility Resident Council Minutes dated 12/5/25, 1/27/26, 2/25/26, and 3/25/26, revealed documentation of resident complaints of cold food being served. Resident #62: Review of the Face Sheet, physician current orders dated 4/26, and care plans dated 5/21/25, revealed Resident #62 was 77 years-old, was admitted to the facility on [DATE], had a guardian in place, and was dependent with all ADL's. The residents diagnosis included, Alzheimer's Disease, diabetes, Dementia, Major depression, wonder, adjustment disorder, spinal stenosis and chronic pain syndrome. The resident had a respiratory, visual and auditory deficit, was a fall risk, and was an elopement risk due to wondering behavior. Review of the residents Fall care plan dated 11/18/25, stated Keep frequently used items within reach, including the residents call light. Observation made on 4/21/26 at 7:37 a.m., revealed the resident in bed with his call light hanging over the electrical call light system on the wall. The call light was approximately 4 to 4.5 feet from the resident, he was unable to reach it and his room door was shut at the time. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview done on 4/21/26 at 7:42 a.m., Nursing Assistant H stated Yes, he can use his call light. Review of the facility Nursing Competency sheet (un-dated), reveled education regarding dignity and stated Understanding better service excellence and how to embed it as a nurse; understand the importance of resident dignity and how to maintain it in this role.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, the facility failed to provide a Stop Date for an as-needed (prn) antipsychotic medication (Ativan) for one resident (Resident #21) of five residents reviewed for unnecessary medications, resulting in no 14-day Stop Date. Findings include.Resident #21: On 4/22/2026, at 1:29 PM, during medication administration task, Resident #21's physician's orders were reviewed and revealed: Ativan Oral Tablet 0.5 MG (milligrams) Lorazepam Give 1 tablet by mouth every 6 hours as needed for anxiety Start Date: 4/4/2026 The End Date column was blank. On 4/22/2026, at 12:30 PM, a record review of Resident #21's electronic medical record (EMR) revealed an admission on [DATE] with diagnoses that included Diabetes Mellitus, Adjustment disorder with Anxiety and Depressed Mood. Resident #21 required assistance with Activities of Daily Living (ADL) and had intact cognition. A review of the care plan (resident) has a terminal/end stage prognosis and requires hospice care provided by (hospice company) Date Initiated: 12/30/2025 . Interventions . Hospice and facility will coordinate plans of care to manage symptoms such as nausea, agitation, pain, uncomfortable breathing, pressure ulcer prevention interventions, nutrition and hydration needs, and psychosocial interventions. Date Initiated: 01/05/2026 . A review of the progress notes revealed: 4/4/2026 18:26 Nurse Note . PRN Ativan reinstated as ordered. A further review of the progress notes revealed no further notations on the PRN Ativan order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235380	A. Building B. Wing	04/22/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update care plans in a timely manner for one resident (Resident #49) of 3 residents reviewed for care plans.Findings include: Resident #49: On 4/20/2026, at 11:06 AM, Resident #49 was lying on their bed awake. The room was dark and the blind was pulled closed. On 04/21/2026, at 8:45 AM, Resident #49 was resting on their bed awake. There was a small bucket of bird seed on the floor. The blind was pulled closed. Resident #49 asked surveyor to pull back the shade to look out the window to see the bird feeder as they offered, they fill the feeder every other day or every other month. On 4/21/2026, at 3:30 PM, a record review of Resident #49's electronic medical record revealed an admission on [DATE] with diagnoses that included cerebral infarction (stroke), Dementia and Major Depressive disorder. Resident #49 required assistance with Activities of Daily Living (ADL) and had severely impaired cognition. A review of the The resident Leisure Preferences are he chooses how to spend his day. He enjoys visit from friends and family. Enjoys feeding and watching birds out his window. Date Initiated: 03/09/2024 Goal Resident will participate in choses activities Date Initiated: 11/06/2025 Target Date: 06/14/2026 Interventions Discussion Groups Very small groups Date Initiated: 09/10/2024 Exercise/Sports Going for walks Date Initiated: 03/09/2024 Having visitors very small groups Date Initiated: 03/09/2024 Hobbies Working and tinkering Date Initiated: 03/09/2024 Music Date Initiated: 09/10/2024 Outdoor activities I like to go outside. I like to go for walks. Date Initiated: 03/09/2024 Outings I sometimes go out with my close friends if they come and get me. Date Initiated: 03/11/2025 Sensory Programs Pet Therapy Date Initiated: 09/10/2024 Television: TV Land, comedies, Date Initiated: 03/09/2024 Volunteering I volunteered to help take care of some plants in the plant nursery on the west end of the building. I water them and turn them to get even lighting. Date Initiated: 03/11/2025 On 4/22/2026, at 8:13 AM, Resident #49 was not in their room. Their blind was opened wide. The bird feeder was full of bird seeds. On 4/22/2026, at 8:28 AM, a record review of Resident #49's Recreational Services: Admission/Quarterly/Sig Change Date: 3/9/3036 assessment revealed the following: . How important is it to you to do your favorite activities? Somewhat important was check marked. Describe resident's favorite activities, special accomplishments and/or new interests. Resident does enjoy watching out his window, spending time with his longevity companion. Additional Comments Resident choses how to spend his day and prefers to be in his room but visits whit his roommate regularly, talks with staff and comes out to common area to people watch. Resident enjoys feeding and watching the birds out his window and gets visits by his friends occasionally . Remains appropriate/current as per current care plan. There was no mention on the care plan regarding feeding the birds or ensuring the blind was open. On 4/22/2026, at 10:54 AM, Longevity Companion (LC) V was interviewed regarding Resident #49. LC V provided they visit three times a week and will help with filling the bird feeder. LC V provided they document in their own program. On 4/22/2026, at 12:10 PM, Activities Director W was asked if the facility had plants for the residents to water and AD W pointed to above the tall storage cabinets in the activity room. AD W planned to follow up. The plants appeared out of reach without a step stool or ladder. On 4/22/2026, at 12:14 PM, AD W entered the conference room and was asked what Resident #49 liked to do and AD W stated, he feeds the birds. AD W was asked if Resident #49 had plants to water would they like that. Both AD W and the Director of Nursing (DON) were alerted that the care plan stated he liked to water plants and that it doesn't reflect that he feeds the birds. The DON voiced to AD W to provide Resident #49 with a plant in their room. On 4/22/2026, at 12:27 PM, Resident #49 was not in their room. AD W was observed in the room opening the blind. There was no plant in the resident's room. AD W was asked if the plants were real and AD W provided some are fake and some are real.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure accurate documentation of care per professional standards of practice for one resident (Resident #2) of one resident reviewed for Peripherally Inserted Central Catheters. Findings include: On 04/20/26 at 10:07 AM, Resident #2 was observed in their room in bed and an interview was completed. When asked if they were being treated for an infection, Resident #2 responded that they were taking an oral antibiotic. With further discussion, Resident #2 revealed they were admitted to the facility with a PICC (Peripherally Inserted Central Catheter- catheter inserted into the arm and feed to the hard for long-term intravenous (IV) therapy) line and IV antibiotics. When queried if they still had the PICC line, Resident #2 verbalized it was removed at the facility. A PICC line was not observed in either of the Resident's upper extremities. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses which included heart disease, Congestive Heart Failure (CHF), diabetes mellitus, Chronic Obstructive Pulmonary Disease (COPD), and Lymphedema (chronic condition causing swelling and skin changes typically in the lower extremities). Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to total assistance to complete ADLs with the exception of oral care and eating. The MDS further specified the Resident was not receiving intravenous medications. Review of Resident #2's Electronic Medical Record (EMR) revealed an active care plan entitled, (Resident #2) is at risk for infection R/T (related to) PICC (Initiated: 4/2/26). The CP included the interventions:- Dressing changes to IV site as ordered (Initiated: 4/2/26)- Flush PICC per protocol (Initiated: 4/2/26)- Monitor PICC site for redness, drainage, swelling, and increase in pain (Initiated: 4/2/26)Review of documentation in Resident #2's EMR revealed an order to remove the Resident's PICC line was received on 4/7/26. The only nurses note related to the discontinuation of the PICC line was. has completed antibiotic course. gave orders to remove PICC line. A review of Resident #2's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2026 revealed the Resident received their last dose of IV antibiotics on 4/6/26 at 10:00 PM and the PICC line was last flushed on 4/7/26 at 11:00 AM. Review of Resident #2's EMR revealed Daily Skilled Nurses Note documentation specifying, Resident is receiving skilled services for. Medication Management/IV Therapy. on:- 4/9/26 at 12:46 PM- 4/10/26 at 10:37 AM- 4/16/26 at 11:08 PM- 4/17/26 at 5:18 PM- 4/18/26 at 10:16 AM- 4/20/26 at 1:30 PM- 4/20/26 at 11:17 PM- 4/21/26 at 11:58 PM Further review revealed a Care Management assessment note dated 4/14/26 at 9:52 AM which detailed, An Ongoing or Discharge Care Management meeting was held. medical barriers to the resident's discharge plan which include. IV antibiotics. An interview was completed with Unit Manager/Infection Control Registered Nurse (RN) Z on 4/22/26 at 7:21 AM. When queried if Resident #2 was receiving IV antibiotics, RN Z responded they were not. RN Z explained the Resident had a PICC line and was receiving IV antibiotics when they were admitted but it had been removed when the IV antibiotics were completed. RN Z was asked when the PICC line was removed and replied, Came in with three days left on IV and then PICC was removed. Resident #2's Daily Skilled Nurses Note documentation was reviewed with RN Z at this time. When queried why nursing staff were documenting IV therapy as a reason for skilled therapy when the Resident is not receiving IV medications, RN Z replied, Medication Management/IV therapy is one box so they must be checking that. When queried how Resident #2's other medications qualified for skilled nursing care, RN Z revealed they did not know. When asked why not all nursing staff indicated a reason for skilled care was medication management/IV therapy on the assessment, RN Z was unable to provide an explanation and indicated they would need to look into it. When queried regarding the Resident having an active care plan for a PICC line, RN Z revealed the care plan should have been discontinued when the PICC line was removed. On 4/22/26 at 8:39 AM, an interview and review of Resident #2's EMR documentation was completed with the Director of Nursing (DON). When (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	queried if nursing documentation in the EMR should accurately reflect the Resident's condition, the DON verbalized it should and stated accurate documentation is a standard of care. When queried if Resident #2 currently had a PICC line, the DON confirmed they did not. A review of Daily Skilled Nurses Note documentation was completed at this time. When queried why some nursing staff were documenting Medication Management/IV Therapy as a reason for the Resident requiring skilled services, the DON verbalized the documentation was inaccurate and Resident #2 was not skilled for medication management. When queried regarding the inaccurate documentation, the DON verbalized understanding of the concern. A policy/procedure was requested at this time. Review of facility policy/procedure entitled, Charting and Documentation (Revised: 11/2020) revealed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's electronic medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that oral care was provided for one resident (Resident #71) of three residents reviewed for Activities of Daily Living (ADL) care. Findings include:Resident #71:On 4/20/26 at 9:50 AM, Resident #71 was observed in their room. The Resident was in bed, positioned on their back. The Resident's hair was unkempt and uncombed. While speaking, Resident #71's teeth were observed to have a significant, visible amount of build up on them. When queried if they are able to brush their teeth themselves, Resident #71 revealed they need help. Resident #71 stated, Not brushed my teeth since been here. With the Resident's permission, a tour of their bathroom and room was completed. One unopened toothbrush was observed in the top drawer of the Resident's dresser.Record review revealed Resident #71 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required set-up and clean-up assistance to complete oral hygiene.Review of Resident #71's Electronic Medical Record (EMR) revealed a care plan entitled, ADLs. requires assist with daily care needs r/t (related to) altered mobility, pain (Initiated: 4/14/26). The care plan included the intervention, Assist resident with ADLs (Initiated: 4/14/26).On 4/22/26 at 8:39 AM, an interview was completed with the Director of Nursing (DON). When queried if Residents, who require assistance. should be offered and assisted to complete oral care on a daily basis, the DON responded that staff should provide oral care. The DON was asked if toothbrushes are changed on a routine basis and responded that a new toothbrush is provided as needed and requested. The DON was informed of Resident #71 stating they had not brushed their teeth since being admitted to the facility as well as observation of their toothbrush being unopened and the visible substance build up on their teeth. When asked, the DON verbalized that was not a standard of care and they would address the concern.Review of facility policy/procedure entitled, Activities of Daily Living (ADL), Supporting (Revised: March 2018) revealed, Policy. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess, monitor and document wound care for two residents (Resident #12, Resident #75) and improperly used a positioning device for one resident (Resident #5) out of three residents reviewed for quality of care, resulting in old, undated wound dressings and no physician's orders for a positioning device. Findings include. Resident #75: On 4/20/2026, at 1:20 PM. Resident #75 was sitting in their wheelchair in their room. They had on an occlusive dressing on their left elbow/forearm that was dated 4/17. Resident #75 stated, he bumped it when he fell the day before. On 4/20/2026, at 1:28 PM, an observation with Nurse U of Resident #75's left elbow dressing was conducted. Nurse was asked what the date was on the dressing and Nurse U stated, 4/17. Nurse U removed the dressing. There was an approximate 1 centimeter (cm) by 1 centimeter skin abrasion. The wound bed was red and shiny. Nurse Ucleansed the area with normal saline and a 4 x 4 cloth which revealed a small amount of bloody drainage noted to the cleansing cloth. Nurse Ustated, they would call the doctor and place an order for treatment to the abrasion. On 4/21/2026, at 10:45 AM, a record review of Resident #75's electronic medical record revealed a readmission on [DATE] after a two-day hospital stay with diagnoses that included Diabetes Mellitus, Pneumonia and Covid Positive. Resident #75 required assistance with Activities of Daily Living and had intact cognition. A review of the Nursing: Admission/re-admission . Skin Evaluation Date: 4/19/2026 revealed General . Skin Integrity . Open Areas . was check marked. There was further notation . Additional Comments: Skin tear noted to left elbow measuring 1cm X 1cm x 0 cm. Bruising noted throughout arms, legs, and left buttock. No other open areas noted at this time . Left elbow Treatment in Place . Is there an order for all wounds that require a treatment? . Yes . was check marked. The Skin Evaluation was started on 4/19/2026 and locked (completed) on 4/20/2026 14:21 (2:21 PM) by Nurse Y. A review of the Physician orders revealed no skin treatment order to Resident #75's left elbow until after Nurse Uassessed the skin tear on 4/20/2026. On 4/22/2026, at 10:10 AM, the Director of Nursing (DON) was asked why Nurse Y would document a skin tear assessment and that there was an order to care the wound on 4/19/2026 without fulfilling the order and leaving the old bandage on the skin tear and the DON offered, he will have to strike it out if it's incorrect documentation. Resident #5: Review of the Face Sheet, nurse's notes dated 2/26 through 4/26, and care plans dated 3/25, revealed Resident #5 was 61 years-old, admitted to the facility on [DATE], alert and able to make own healthcare decisions, and dependent on staff for Activities of Daily Living. The resident's diagnosis included, low back pain, muscle wasting, muscle weakness, osteomyelitis, sacral wound, urinary catheter in place, adjustment disorder, major depression and chronic kidney disease. Observation made on 4/21/26 at 12:45 p.m., in the resident's room revealed, a dark blue positional device/wedge on the floor at the bottom of the resident's bed. The blue wedge/positional device was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted to be dirty. During an interview done on 4/21/26 at 12:45 p.m., the resident stated They (staff) use it to get me off my hip, and for my butt; they put it on and take it off. Review of the resident's physician orders and care plans (dated 2/25, thorough 4/26), revealed no order for this device/wedge. Review of the resident's care plans from 11/25 to 4/26, revealed no documentation of a positional device or wedge. During an interview done on 4/21/26 at1:00 p.m., OT C reviewed the resident's orders and stated, There is no order or care plan for that positional device, it's not from therapy. During an interview done on 4/21/26 at 1:48 p.m., East Unit Manager, LPN D stated There should not be any positional devices in her room, I don't know where it came from, there is no order and it's not on the care plans. I am going to take it out of there. During an interview done on 4/21/26 at 2:50 p.m., Charge Nurse, LPN G stated I do have her hall, I have no idea where it (blue positional device) came from, I did not see it in there. During an interview done on 4/22/26 at 8:00 a.m., the Director of Nursing said there should not be a wedge/device on her bed (Resident was on an Easy Air mattress-air mattress for decrease pressure on sacral area for wound healing). During a phone interview done on 4/22/26 at 8:25 a.m., mattress company representee E stated It's for sure going to affect the way it alternates for larger people; do not use wedges other then on head or feet areas with that mattress she is on. Resident #12: In an observation and interview on 04/20/2026 at 9:39 AM with Licensed Practical Nurse (LPN) F, it was observed that the right forearm had a 4x4 boarder dressing in place with no date or initials on the dressing. Resident #12 was seated up in wheelchair in her room and could not recall when the dressing was applied or by whom. LPN F was not aware that the resident had a dressing to the right forearm. Resident #12 stated that the lift sling ripped her skin open. Observation on 04/21/2026 at 7:19 AM by the state surveyor of Resident #12's right-forearm noted 4x4 boarder dressing in place with no date or initials appears to be the same dressing as the previous day, Resident #12 stated that nobody changed it. Observation and interview on 04/21/2026 at 12:32 PM with Licensed Practical License (LPN) D unit manager was taken to the main ding room to observe Resident #12's right forearm dressing. LPN D observed a 4x4 boarder dressing with no date, time or initials on the dressing of right forearm. In an interview and record review of Resident #12's medical record revealed that there were physician orders for treatment and there was no order for a dressing to the right forearm. LPN D stated that there is no treatment on the Medication Administration Record (MAR) or Treatment Administration (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record (TAR). Record review of Resident #12's Incident report. dated 4/17/2026, revealed that a staff member alerted the nurse to a skin tear on the residents' right forearm approximately 3.5cm x 1.5cm, tear from Hoyer pad during transferring. Record review of the 'Wound Care' policy, dated 4/2026, revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Steps in procedure: (9.) [NAME] the dressing with initials, time, and date.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to prevent the development of facility-acquired Deep Tissue Injuries (DTI) for two residents (Resident #6, Resident #29) of 6 residents reviewed for wounds.Findings include: Resident #6:Record review of Resident #6's 2/12/2026 significant change Minimum Data Set (MDS) section M: Skin conditions noted that the resident was at risk of developing pressure ulcers/injuries, but that the resident had no unhealed pressure ulcers/injuries at the time of the assessment. During an observation on 04/20/2026 at 9:46 AM, Resident #6 was sleeping/resting on top of the covers on the bed with regular socks on her feet. There were gray soft boots (Prafo boots) with Velcro straps located in the wheelchair at bedside. The protective boots were not on the resident while in the bed. Resident #6's heels were resting on the mattress. The state surveyor observed slight right ankle/foot swelling. There were no extra pillows noted in room for heel elevation or offloading. Record review of Resident #6's progress notes, dated 2/5/2025 at 8:08PM, noted a fall on 2/3/2026 that resulted in a fracture of the left fifth metatarsal and was assessed of the left foot with some bruising and edema, painful to the touch, range of motion was limited with pain and weakness . tired/lethargic appearing. Record review of progress note, dated 3/12/2026 at 4:21PM, revealed that upon skin assessment the resident was noted to have a blister that was irregular in shape and size. Surrounding skin is red in color and blanchable. Blister is likely from resident wearing orthopedic boot with gripper socks and was caused by friction Progress note dated 3/22/2026 at 10:59 AM, skin/wound: Resident continues with abrasions to lower back and left buttocks. Also continues with area to left foot with current treatment . Progress note 4/10/2026 at 00:30AM noted to be lethargic and tired this shift . 4/13/2026 at 8:47Am resident very lethargic AM medications not given at this time . On 4/15/2026 at 3:53PM residents noted to have fluid filled blister to right heel. Approximately 4.00 x 4.00 cm in size, Area cleansed with normal saline and betadine and covered with dry dressing . Record review of Resident #6's 'Wound Assessment Details Report', dated 4/15/2026, revealed that on 03/12/2026 a left outer foot facility-acquired blister to back of left heel and a new facility-acquired right heel blister measuring 4.0 x 4.0 cm. In an observation on 04/20/2026 at 3:10 PM, Resident #6 was observed in bed asleep with no gray soft boots (Prafo boots) on, feet/heels were resting on the mattress. No pillow to elevate heels and no boots on. Observation of the resident's room located the soft gray boots (Prafo boots) on top of the closet/wardrobe behind the entrance door. In an observation on 04/21/2026 at 7:22 AM with Registered Nurse K, the resident was in bed with no covers on and her legs/heels were on the mattress again. The soft heel protector boots (Prafo boots) were off while resident was in bed off. Observation and interview were conducted on 04/21/2026 at 11:33 AM of Resident #6 with Registered Nurse K. Observation of resident's heels bilateral revealed a right heel- with a blood-filled blister, deep tissue injury, dark black in color betadine on the blister, The blister was fifty-cent-coin sized. It was estimated at 3.5 inches long and 2 inches wide and stuck up 1/2 inch or more. RN K stated that it it was not there when RN K worked last week. Observation o the left heel revealed an anterior dime=sized, and dried deep tissue injury. Also, the back of the heel has a dark deep tissue injury, dime-sized in appearance. RN K stated that the right heel deep tissue is a new injury. Record review of the facility's 'Prevention of Pressure Injuries' policy, dated 4/2020, revealed that the purpose of the procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Skin Assessment: (3.) Inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living (ADLs). B. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) E. Reposition resident as indicated on the care plan. Device related pressure injuries: review selected medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device. Monitor regularly for comfort and signs of pressure-related injury . Resident #29:Observations and an interview were conducted on (continued on next page)

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	235380	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Rose City	517 West Page Street Rose City, MI 48654

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/20/2026 at 9:54 AM with Resident #29 accepting the state surveyor observing care. Resident #29 was being prepared for a Hoyer transfer to a wheelchair. During the observation the surveyor noted a Krelix dressing on the left foot heel area with no date, time or initials. Observation of the dressings on the left foot with no dates or time noted, were observed by Certified Nursing Assistants (CNA) H and R. Record review of Resident #29's Minimum Data Set (MDS) dated [DATE] section M: Skin conditions, revealed that the resident was at risk of developing pressure ulcers/injuries but had no actual observed pressure ulcers/injuries. Record review of Resident #29's 'Wound rounds' page in the electronic medical record (EMR) revealed on 01/14/2026 a left heel pressure injury. Record review of the 1/14/2026 'Weekly Skin Check/Skin Condition' form noted a 1.0 cm x 1.0 cm pressure area, dark purple in color, and redness to bilateral heels. Observation and interview were conducted on 04/22/2026 at 7:52 AM with the Licensed Practical Nurse (LPN) Unit Manager D of Resident #29's facility-acquired pressure injury to the left heel. LPN D stated that the left heel wound was facility acquired and that it is healing. LPN D was taken to Resident #29's room and observed the dressing to the left heel. Observation of the left heel dressing, undated again, revealed that krelix and the 2 x 2 border dressing with betadine were removed. Observation revealed an open area with flaked off skin, deep tissue injury was noted. LPN D stated that there should have been a date, time and initials of the staff member performing the dressing change on the dressing. Record review of the facility's 'Wound Care' policy, dated 4/2026, revealed that the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Steps in procedure: (9.) [NAME] the dressing with initials, time, and date. Record review of the facility's 'Moving and Positioning' policy, undated, revealed pressure injuries can occur in high-risk areas such as bony prominences or where a bone is lying directly on top of another bone. Bony prominences are the areas of the body where a bone lies close to the skin's surface, such as the back of the head, shoulders, elbows, heels, ankles, tops of the toes, hips, and coccyx (i.e., tailbone). These areas are most susceptible to developing pressure injuries because they have the leastamount of cushioning. Placing pillows or other specialized equipment reduces the pressure inthese areas and also helps to prevent the resident from rolling out of position Moving residents must be done carefully because their skin can easily be damaged by improper handling. Due to the effects of aging on the integumentary system, older adults can develop pressure injuries from friction and shear when repositioned or from lying in one position for long periods of time in bed. Pressure injuries (formerly called pressure ulcers or bedsores) are localized damage to the skin or underlying soft tissue, usually over a bony prominence, as a result of intense and prolonged pressure and/or shear . If a resident is highly susceptible to pressure injuries of the heels, they may have specialized soft foam boots that support the ankles and keep the heels floated off the bed. A foot cradle may also be used to keep sheets and blankets off the tops of the toes if the resident has a history of skin injury in that area.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide sanitary nebulizer storage for one resident (Resident #2) and provide safe oxygen administration for one resident (Resident #77) of two residents reviewed for respiratory medication needs. Findings include. Resident #2: On 04/20/26 at 10:07 AM, Resident #2 was observed in their room in bed. A nebulizer machine was observed on the dresser next to the resident's bed. The nebulizer tubing was observed going into the top dresser drawer. A nebulizer mask was sitting in the drawer. The mask was uncontained and connected with visible fluid present in the medication administration chamber. An interview was completed at this time. When queried if they were receiving nebulizer treatments, Resident #2 confirmed that they were. Record review revealed that Resident #2 was admitted to the facility on [DATE] with diagnoses which included heart disease, Congestive Heart Failure (CHF), diabetes mellitus, Chronic Obstructive Pulmonary Disease (COPD), and Lymphedema (chronic condition causing swelling and skin changes typically in the lower extremities). Review of the MDS assessment, dated 4/9/26, revealed that the Resident was cognitively intact and required moderate-to-total assistance to complete ADLs with the exception of oral care and eating. Review of Resident #2's Electronic Medical Record (EMR) revealed a care plan entitled, Respiratory: Resident has potential for difficulty in breathing. (Initiated: 4/2/26). The care plan included the intervention, Administer medications/treatments as ordered (Initiated: 4/2/26). Review of Resident #2's Medication Administration Record (MAR) for April 2026 revealed the Resident had an order for DuoNeb (prescription inhalation medication used to treat shortness of breath) breathing treatments every six hours from 4/12/26 to 4/19/26. On 4/21/26 at 12:05 PM, Resident #2 was observed in their room in bed. The nebulizer administration mask was observed in the top drawer of their dresser, connected with visible fluid in the mediation administration chamber. An interview was conducted with the Director of Nursing (DON) on 4/21/26 at 1:53 PM. When queried regarding the facility policy/procedure for storage of nebulizer treatment administration equipment following use, the DON stated, Should rinse and let air dry on a paper towel and then put in a bag which gets changed weekly. The DON was informed of observation of Resident #2's nebulizer mask and stated, That is a concern. Resident #77: On 4/20/2026, at 11:00 AM, Resident #77 was sitting in their wheelchair in their room. They had oxygen on via a nasal cannula. On 4/20/2026, at 11:20 AM, Resident #77 was noted to be gone out of their room. The oxygen cannula was lying on the floor with the concentrator running. On 4/20/2026, at 11:30 AM, Nurse U was asked if they knew where Resident #77 was and Nurse U (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered, out of the building at dialysis. On 4/20/2026, at 11:35 AM, an observation of Resident #77's oxygen nasal cannula that was running and on the floor was conducted with Nurse U. Nurse U was asked if that was normally on the floor while running and Nurse U provided oh, I will take care of that. Nurse U donned personal protective equipment and discarded the tubing and shut off the concentrator. On 4/21/2026, at 11:00 AM, a record review of Resident #77's electronic medical record revealed a readmission 4/14/2026 with diagnoses that included Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD) and Dependence on Renal Dialysis. Resident #77 required assistance with daily care needs and had intact cognition. A review of the Resident has oxygen therapy r/t(related to) COPD Date Initiated: 04/15/2026 . Interventions . OXYGEN SETTINGS: O2 via N/C at 2-4 LPM . There was no intervention noted regarding oxygen safety instructions. According to the American Lung Association Oxygen Safety Guidelines, . Turn off your oxygen when you're not using it .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **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 #5) of 5 residents reviewed for medication storage were properly stored.Findings Include: Resident #5: Review of the Face Sheet, nurse's notes dated 2/26 through 4/26, and care plans dated 3/25, revealed Resident #5 was 61 years-old, admitted to the facility on [DATE], alert and able to make own healthcare decisions, and dependent on staff for Activities of Daily Living. The residents diagnosis included, low back pain, muscle wasting, muscle weakness, osteomyelitis, sacral wound, urinary catheter in place, adjustment disorder, major depression and chronic kidney disease. Review of the residents Mood problem care plan dated 11/11/24, revealed staff were to administer mediations as ordered and monitor for side effects. Review of the facility medication Preparation and General Guidelines policy dated May 2022, revealed all resident medications were to given per the 5 Rights of Medication Administration (including proper identification of any medication and documentation of all medications/treatments (including checking the TAR-Treatment Medication Record) prior to giving. No medications or topical treatments were to be left at the bedside or any place in residents room unattended.Observation was done on 4/21/26 at 8:00 a.m., in the residents room. Next to the sink sitting on the counter was a small cup of liquid approximately 1/4th full of Diakins (used for wound care). On the cup was written with black marker the word Dankins, no top on the cup, and no resident name or any dates were found on the cup.During a second observation done on 4/21/26 at 11:30 a.m., was found a opened and partly used tube of Dicofenac Sodium Topical 1% (used for arthritis pain/discomfort); this was seen sitting on the residents bedside table, with no name and no dates on the tube.Review of the residents orders dated 11/24 through 4/26, revealed documentation that Dicofenac Topical cream was ordered for the resident on 11/11/24, and discontinued on 1/6/25.Review of the residents EMAR (Electronic Medication Administration record) and TAR (Treatment Administration Record) dated 4/26, revealed no order or documentation of the resident getting Dicofenac topical cream.Review of the resident orders dated 12/14/26, revealed Dankins was to be used on the residents sacral wound as a treatment. Review of the EMAR dated 4/26, revealed staff were using the Dankins on her sacral wound as ordered.During an interview done on 4/22/26 at 11:15 a.m., East Unit Manager, LPN stated It (the Dicofenac) was discontinued, it should not have been in her room and the Dankins should not have been in a cup her room, I don't know what to say.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide fresh fluids at bedside for one resident (Resident #49) of six residents reviewed for bedside fluids. Findings include. Resident #49: On 4/20/2026, at 11:06 AM, Resident #49 was lying on their bed awake. There was one Styrofoam cup noted on their nightstand. The cup appeared to have brown liquid in it and the cup had a date written on it of 4/18. There was an empty coke bottle on their overbed table. Resident #49 provided they got it out of the machine. There were no other fluids at bedside. On 4/20/2026, at 11:55 AM, Certified Nursing Assistant (CNA) S was asked if Resident #49 had been provided a cup of water and CNA S provided that Resident #49 usually only wants chocolate milk. On 4/20/2026, at 11:59 AM, an observation along with CNA S of Resident #49's Styrofoam cup. CNA S was asked what the date and fluid was and CNA S offered, 4/18 and it's chocolate milk. CNA S reassured the resident they would get a new cup of milk for them as it was old. Resident #49 stated, they just gave it to me and it's half full. On 4/21/2026, at 3:30 PM, a record review of Resident #49's electronic medical record (EMR) revealed an admission on [DATE] with diagnoses that included cerebral infarction (stroke), Dementia and Major Depressive disorder. Resident #49 required assistance with Activities of Daily Living (ADL's) and had severely impaired cognition.