

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER The Villa at West Branch		STREET ADDRESS, CITY, STATE, ZIP CODE 445 South Valley Street West Branch, MI 48661	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 notify a representative of the Office of the State Long-Term Care Ombudsman's office of pending transfers/discharges for the last three years and for two residents (Resident #6, Resident #10) 2 residents reviewed for hospitalization, resulting in the lost opportunity of the State Office of Long-Term Care Ombudsman's office to offer additional support and advocacy to the residents with no notice of pending transfers/discharges for 3 years. Findings include:Resident #6: Record review of Resident #6's February 2026 progress notes revealed that the resident was sent to the hospital. Resident #6 was readmitted on [DATE]. Resident #10:Record review on 06/09/2026 at 4:16 PM of Resident #10's admission/discharge census tab revealed that Resident 10 was hospitalized at 2/27/26 for 24 hours and discharged to hospital on 5/4/2026 and returned on 5/7/2026 to facility. In an interview on 06/08/2026 at 11:42 AM while sitting in the main dining room the resident could not recall why he went to the hospital. Possible infection he did not know. but he came back to the facility. In an interview on 06/10/2026 at 11:50 AM the Corporate Operations Consultant (COC) J and the Nursing Home Administrator (NHA), revealed that the facility has not sent the ombudsman notification of transfers/discharges/or admissions for three (3) years. The facility social worker was a designee and had not been sending the Ombudsman notifications. THE COC stated that the sister facility does send the Ombudsman notices as required by regulation, but that the current facility does not have. The COC stated that there were no notice records to review. In an interview and record review on 06/10/2026 at 12:04 PM, the Regional Social Worker (RSW) K stated that the corporation does yearly training for the 21 buildings owned with the social workers. RSW K revealed that there was a form/spreadsheet format with date/transfer/disposition that the social service designee was to send at the end of the month to the state long-term ombudsman. Record review of the corporate educational material noted a power point presentation and spreadsheet form to fill out. Record review of the facility 'Transfer and Discharge Guidelines' revised date 5/5/2025 revealed: Notifications- The interdisciplinary team designee will meet with the resident and resident representative as applicable to review the discharge/transfer notice and its contents. (c.) A copy of the discharge notice is sent to the State Office of Long-Term Care Ombudsman. The Ombudsman office may offer additional support and advocacy to the residents.		

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive Infection Control (IC) program including 1) Accurate outcome and process surveillance comprising identification of potential trends and a system to identify and prevent spread of potential infections and communicable disease 2) Hand hygiene during meals, 3) Enhanced Barrier Precautions for one resident (Resident #12), 4) Cleaning of multi-resident use glucometers, and 5) Maintenance of indwelling urinary catheters in a sanitary manner for one resident (Resident #11) resulting in a lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis. Findings include: Dining Observation: Observation on 06/08/2026 at 11:46 AM of the main dining room revealed 24 residents seated in the dining room with two dietary staff and two Certified Nursing Assistances (CNA) in the room assisting with beverages being passed to residents. Staff and residents hand hygiene was not observed as being performed. Observed staff to pass trays with no hand sanitation between trays, staff remove lids and set up the residents and apply the clothing protector and move onto the next the resident. No hand hygiene offered to residents prior to meal or post meal. Observation on 06/9/2026 at 12:24 PM observations of hallway tray pass for the noon meal revealed no hand hygiene offered to residents pre or post meal. Record review of the facility 'Dining Experience Guideline' dated 4/11/2023 noted that to provide a positive dining experience for residents, staff will be educated on hygienic practices and be able to perform properly hygiene for the safety of the residents. Residents will be offered hand sanitizer . Enhanced Barrier Precautions during Medication Administration: Observation was made on 06/09/2026 at 9:02 AM with Registered Nurse (RN) I of Resident #12's Vancomycin 1.25gm/250ml normal saline bag to a Peripherally Inserted Central Catheter (PICC) line double lumen, with Total Parenteral Nutrition (TNP) in one port. PICC line occlusive Dressing date 6/7/26, Blue caps noted on ports, RN I donned Gloves, picked up the port, scrubbed with alcohol wipe, flushed with Normal Saline 10 ml syringe flush, connected the vancomycin 1.25gm/250ml NS bag, programed the medication pump at 167ml per hour/ for 250 ml, to run 90 minutes. Removed her gloves and walked out of the room. The state surveyor noted a red 'Enhanced Barrier Precaution' sign posted below the resident's room number to the left side of the doorway upon entrance to the room. No enhanced barrier of a gown was worn while in the room. In an interview on 06/10/2026 at 7:47 AM, Infection Control Preventionist (ICP) B explained the procedure for Enhanced Barrier Precautions. ICP B described that the nurse should have gone into the room, washed her hands, gloved and gowned, to protect the spread of infections, before touching the PICC line, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility 'Enhanced Barrier Precautions' policy, dated 3/2024, revealed that Enhanced Barrier Precautions (EBP) are utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. EBP employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity . Glucose Monitoring Cleansing: In an observation on 06/09/2026 at 7:31 AM, Registered Nurse (RN) I went to perform glucose blood sugar check for unsampled Resident in room [ROOM NUMBER], blood sugar check 103. RN I placed the glucose monitor device into a clear plastic cup along with alcohol wipes and lacets. RN I went back to the medication cart to document the blood sugar level in the resident record. RN I stated that she likes to check resident blood sugars before the breakfast meal for glucose levels. The state surveyor continued to observe RN I as she checked for the next residents record for blood sugar checks. No glucose machine cleaning was performed, left in the clear plastic cup. Observation on 06/09/2026 at 7:35 AM with RN I of Resident #59's blood sugar check of 148, no insulin was needed. RN I placed the glucose monitor device into a clear plastic cup and went back to the medication cart to document the blood sugar level in the resident record. No glucose machine cleaning was performed, left in the clear plastic cup. Observation on 06/09/2026 at 7:40 AM with Registered Nurse (RN) I went to perform glucose blood sugar check of Resident #19, blood sugar check 77. RN I placed the glucose monitor device into a clear plastic cup and went back to the medication cart to document the blood sugar level in the resident record. No glucose machine cleaning was performed, left in the clear plastic cup on top of the medication cart. Record review of the facility 'Blood Glucose Meter Cleaning' policy, dated 10/5/2018, revealed if blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions to prevent carry-over blood and infectious agents. Disinfection protocol: Glucometers shared by multiple patients will be thoroughly wiped and allowed to air dry after every use and between every patient: Use a fresh wipe each time the glucometer is used, wipe all surfaces, top, bottom and sides, allow to air dry before use on the next resident Observation was made on 06/09/2026 at 7:50 AM with Registered Nurse (RN) I of Medication room [ROOM NUMBER] with Pyxis medication dispensing machine to get the Lisinopril 10mg tablet. RN I stated that she needed 5mg and needed to cut the tablet in half. RN I cut the tablet in half with a pair of bandage scissors from the treatment cart in the medication room. RN I cut the table into her bare hand and put half of the tablet into the drug buster bottle. Observation was made on 06/09/2026 at 7:58 AM with Registered Nurse (RN) I of medication administration. Resident #59 received Dorzol/Timol 2-0.5% one drops to both eyes was administered, and oral tablets given all with the same pair of gloves. RN I rearranged items on the over bed table and then administered the second eye drop Brimonidine 0.2% eye drop one in both eyes was administered, with the same pair of gloves, In an interview on 06/10/2026 at 7:22 AM, Licensed Practical Nurse (LPN)/Infection Control (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	increased. There were 13 cases of Covid in December. Upon first positive test, residents and family were notified, residents were placed on covid monitoring. Contact/Droplet precautions implemented. The facility implemented covid outbreak precautions and activities and meals were held in rooms. Testing was completed for all positive residents on day 3, 5, and 7. If negative on any tests, residents were able to discontinue contact/droplet precautions. The summary did not specify what type of testing was completed for diagnosis of Covid-19 infection. When queried regarding the summary indicating Covid positive residents were on droplet precautions (procedural or surgical mask and eye protection) and not airborne precautions (N-95 respirator mask), LPN B indicated an N-95 mask was utilized. The facility policy/procedure for Transmission Based Isolation Precautions (TBP) was requested at this time. When queried if the information in the summary meant there were 32 total infections that were treated with antimicrobial medications (20 in-house plus 12 from the hospital) plus the 13 Covid positive infections for a total of 45 infections during the month, LPN B confirmed. Review of the line list for December 2025 included 33 infections treated with antimicrobial medications and 13 Covid infections for a total of 46 infections. The mapping tool indicated 32 infections with antimicrobial treatment and 13 Covid infections for a total of 45 infections. When queried regarding the discrepancies in the number of infections, LPB B confirmed the discrepancy. The line list for the month included the sections, Etiology, Resident Name, Unit, Room, Current Prescription, Infection Type, Infection, Infection Site, Diagnosis, Isolation. Resident #62 was included on the line list as having a facility acquired viral skin infection caused by Herpes Simplex Virus (HSV- Lifelong viral infection which can cause painful blisters or ulcers. There are two types of HSV. HSV-1, commonly called oral herpes, and spread person to person through saliva. HSV-2, commonly called genital herpes, is spread person to person through sexual contact). The line list specified the Resident was on isolation and received Acyclovir (antiviral medication) 800 milligrams (mg) from 11/29/25 to 12/6/26. The line list did not include what the Resident's sign/symptoms were, when the signs/symptoms started, if any diagnostic testing was completed, and when/what type of TBPs were implemented. When queried what type of precautions were implemented, LPN B responded, It would have been contact. LPN B was asked what date the Resident was placed in TBP and responded, It would have been when we noticed it. When queried the date that the Resident's symptoms began and what their symptoms were and LPN B revealed they would need to review the Resident's Electronic Medical Record (EMR) as the information was not included on the line list. LPN B was then asked if a Health Care Provider (HCP) order was required for TBP and stated, Yes. Review of Resident #62's EMR revealed an order dated 12/1/25 for Contact Isolation r/t (related to) dx (diagnosis) of Shingles (herpes zoster- viral infection caused by the varicella-zoster virus). LPN B was asked if the Resident had HSV or shingles and responded shingles. When queried if a laboratory Polymerase Chain Reaction (PCR) swab test was completed to diagnose Shingles, LPN B responded that the HCP diagnosed shingles and no testing was completed. When asked why the line list specified the Resident had Herpes Simplex not shingles (herpes zoster), LPN B did not provide an explanation. When queried why Acyclovir was started on 11/29/25 and precautions were not initiated until 12/1/25, LPN B was unable to provide a rationale. When asked when the Resident's signs/symptoms of infection started and what they were, LPN B began reviewing the Resident's (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	further explanation. When queried, LPN B revealed they were unfamiliar with the Federal Regulations and F-tags related to IC in nursing homes and had not been provided the information. Review of facility policy/procedure entitled, Infection Prevention and Control Program (Dated 2017) revealed, It is the policy that this facility's Infection Prevention and Control Program (IPCP). prevent, recognize and control the onset and spread of infection. The IPCP program includes: 1. A system for preventing, identifying, reporting, investigating and controlling infections and communicable disease. The facility policy/procedure for Transmission Based Isolation Precautions (TBP) was requested but not received by the conclusion of the survey. Review of facility provided policy/procedure entitled, Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19) (Revised: 6/2025) revealed, Guideline: It is the practice of this facility to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to Federal and State/Local recommendations (to include, for example: Admissions, Visitation, Precautions: Standard, Contact, Droplet and/or Airborne Precautions, including the use of eye protection). When the facility is in a COVID-19 outbreak (meaning 1 or more resident cases) universal masking is the decision of the Director of Nursing (DON), unless otherwise dictated by the local health department or the CDC. Personal Protective Equipment HCP (Health Care Providers) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Transmission Based Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Dining Observation on 6/8/26: Observation made on 6/8/26 at 11:54 a.m., in the main dining room, revealed staff were serving the residents' their noon meal. Staff were noted to go resident-to-resident (setting meal on tables, taking plastic wrap off foods and putting on clothing protectors) and not washing their hands or using hand sanitizer between residents'. During an interview done on 6/10/26 at 7:45 a.m., Infection Control Nurse, LPN B stated They (staff) should wash their hands between residents when serving foods. I educate them on handwashing. Review of the facility Handwashing/Hand Hygiene policy, dated May 2022, stated Before and after direct resident contact, before and after eating or handling food. Alcohol-Based Hand Rubs: Before and after direct contact with residents'. Review of the facility Hand Hygiene Guideline dated 4/16/2025, stated The following are indications for hand hygiene: Before eating or assisting a resident with meals.		

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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 interview and record review, the facility failed to ensure the dignity of residents by not answering residents' call lights in a timely manner for 6 of 7 confidential residents from the Resident Council Group, and 1 resident (Resident #57) of 20 sampled residents reviewed for dignity, resulting in anger, frustration, depression, verbalizations of being embarrassed, and a resident soiling themselves. Findings Include: Resident #57: Review of the Face Sheet, nurse's notes, Cognitive assessment tool (BIMS), dated 3/12/26, and care plans, dated 12/25 to 6/26, revealed Resident #57 was [AGE] years old, alert (BIMS of 14), her own person, admitted to the facility on [DATE], dependent on staff for Activities of Daily Living/ADL. The residents' diagnosis included Depression, Anxiety, Bipolar, Fibromyalgia, obesity, difficulty walking, and chronic kidney disease. During an interview done on 6/8/26 at 11:30 a.m., Resident #57 stated, I had to wait one time over an hour and I did wet myself, yes it's embarrassing, it p .ed me off. I don't think that's right. On the weekends it's really bad, especially at night. It takes them about half an hour to answer my light. Sometimes they shut it off and don't take care of me. They don't have enough staff. During the confidential Resident Council Meeting held on 6/9/26 at 2:00 p.m., 6 of 7 resident's verbalized staff don't answer call lights timely on night shift and on the weekends. 6 confidential residents said it takes approximately 30 minutes for staff to answer their lights and stated, There is not enough staff on the weekends, and if there is a call-in, the nurse does not replace them. It takes them (staff) at least a half an hour to answer them, or they (staff) come in and shut it off and don't take me to the bathroom, they say the aide will come in. It's mostly on the weekends, everything is lax on the weekends. They (staff) sit residents by the nurse's station; no TV, no music, nothing for them. An unidentified Certified Nursing Assistant (CNA) tells us to just wet our pants. Review of the Resident Counsel meeting notes dated 5/5/26, stated Concerns: Waiting for call light to be answered. Review of the Resident Counsel meeting notes dated 2/3/26, stated Call lights where Residents can. Review of the Resident Counsel meeting notes dated 11/11/25, stated Call light's not being answered in a timely manner. Review of the facility Answering the Call Light policy dated 11/2013, stated Answer the call light as soon as possible. Review of the facility Resident Rights policy dated 11/28/2017, stated resident's have the right to be treated with respect and dignity.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safe medication storage, dispose of expired medications, date multi-dose open medications/treatments and date a glucometer stick bottle for 2 of 4 carts reviewed and 2 of 2 treatment carts reviewed and for two residents (Resident #39, Resident #59), resulting in expired medications/treatments, opened and undated medications/treatments, and medications left at residents' bedsides. Findings Include: Resident #39: Review of the Face Sheet, orders dated 8/26, and nursing note's dated 5/26 through 6/26, revealed, Resident #39 was [AGE] years old, admitted to the facility on [DATE], had a cognitive assessment score dated 1/5/26, of 5 (BIMS-5: cognitively impaired), and was dependent on staff for all Activities of Daily Living/ADL's. The residents' diagnosis included Stroke with Hemiplegia and right sided Hemiparesis, Memory Deficit, Diabetes, Chronic Lung Disease, Alzheimer's disease and Post-Traumatic Stress. The resident had coccyx wounds being treated with topical medication. Review of the facility Medication Storage policy dated May 2022, stated Medications and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments containing medications and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Observation made on 6/8/26 at 11:00 a.m., during the initial tour revealed Resident #39 in his bed, there was a urinalysis specimen cup filled with a thick white cream sitting on the stand by his bed. No resident name, room number or topical medication name was on the container. During an interview done on 6/8/26 at 11:10 a.m., Nurse Manager, RN A was unable to identify the white cream in the specimen cup, and said it should not have been at the residents bedside, it should not have been in a urine specimen cup in the first place, and no medication was to be put in a different container then what it came in. Nurse Manager A took it out of the room. Medication Storage and Labeling: Observation and interview on 06/08/2026 at 9:25 AM with Registered Nurse (RN) Nurse G standing at the opened medication cart located on A hall, the surveyor reviewed the medication cart and located two small peach-colored tablets with EP 155, non-scored tablets loose in the second drawer of cart. RN G could not state why tablets were loose in the cart. Observation revealed facility used punch out pill cards for medication administration/bubble packs. Computer research of the peach-colored tablets EP-155 were identified as hydrochlorothiazide 12.5mg tablets. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 06/09/2026 at 7:02 AM with Licensed Practical Nurse (LPN) L Review of the D-E hallway medication cart revealed that the Ultra trak glucose test strips were opened and not dated. LPN L stated that she went through the medication cart the previous day to mark all containers. Observation of Resident #43's Ventolin inhaler label peeled off and there was no date on the bag or device when opened. Observation of the Ventolin inhaler had no red tape on the end and the device is used. Observation and interview was conducted on 06/09/2026 at 8:47 AM of the Medication room [ROOM NUMBER] located on the A-B Unit with Registered Nurse I. It revealed treatment cart drawers contained: Coloplast hydrophilic wound dressing cream 6oz., multi-dose tube used, opened with no date when opened, green pain-relieving gel 4oz tube with menthol multi-dose tube used, opened with no date when opened. Coloplast Collagen dressing wound hydrogel 3 oz multi-dose tube used, opened with no date when opened. Solosite wound gel 3 oz. pharmacy date issued 2/2016 with manufacture expiration date 8/1/2025 x 2 tubes, both multi-dose tubes were used, with no date when opened. SilvaKollagen gel silver collagen wound gel manufacturer date expiration date 1/4/2026 was multi-dose tube used, opened with no date when opened, Derma Syn/Ag silver antibacterial wound gel manufacturer expiration dated 3/29/2025 multi-dose tube was available in the treatment carts for use. Observation on 06/09/2026 at 2:08 PM with Licensed Practical Nurse (LPN) M of the Medication Cart C1 revealed Resident #69's Olanzapine 5mg 30 tablet multi-dose bottle dispensed 5/28/26 take 1 tablet 2 times daily. There was no date when the bottle was opened. Observation and interview were conducted on 06/10/2026 at 9:20 AM with acting Director of Nursing (DON) about the lack of glucometer cleaning and enhanced barrier precautions are not used, when a sign clearly states to use on a resident 's door. The DON agreed that the glucometer needs to be cleansed and air dried between residents and that enhanced barrier precautions should be followed by all staff. The state surveyor walked with the DON to review Medication room [ROOM NUMBER] on the A-B unit: Treatment cart review-Coloplast hydrophilic wound dressing cream 6oz., multi-dose tube used, opened with no date when opened, [NAME] pain-relieving gel 4oz tube with menthol multi-dose tube used, opened with no date when opened. Coloplast Collagen dressing wound hydrogel 3 oz multi-dose tube used, opened with no date when opened. Solosite wound gel 3 oz. pharmacy date issued 2/2016 with manufacture expiration date 8/1/2025 x 2 tubes, both multi-dose tubes were used, with no date when opened. SilvaKollagen gel silver collagen wound gel manufacturer date expiration date 1/4/2026 was multi-dose tube used, opened with no date when opened, Derma Syn/Ag silver antibacterial wound gel manufacturer expiration dated 3/29/2025 multi-dose tube was available in the treatment carts for use. All the same treatment creams or ointments were still in the treatment cart available for nursing staff to use in wounds as on the previous day. The DON stated that 'We have expired wound care treatments that are expired and available for use in the cart. the treatment cart is not being monitored. The facility has a wound treatment nurse Licensed Practical Nurse (LPN) H. The state surveyor and DON went to the Unit managers' office to speak with LPN H. In an interview and observation on 06/10/2026 at 9:30 AM, Licensed Practical Nurse (LPN)/Wound Care/unit manager/Restorative H stated that the Treatment carts are in cared for by floor nurses, As the wound care nurse LPN H stated that she does use the treatment carts when doing wound rounds, (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	once a week normally Wednesday, LPN H stated that she did the dressing changes for the building already for the day. LPN H stated that the Treatment carts were reviewed couple weeks ago, LPN H stated that she audited the carts on 5/26/2026 I do it all within the same 2 days but does not document anything. LPN H agreed that multi-dose treatment/creams should have an open date when first used. Observation while in the Medication room on the D-E Unit medication room [ROOM NUMBER] revealed: Triad hydrophilic wound dressing 6 oz. multi-dose tube was opened and not dated. Triamcinolone acetonide cream 1% tube used not dated Iodosorb 10g tube 0.35oz was used and opened and not dated with no resident name on the tube or box. Record review of the facility pharmacy 'Medication Storage in The Facility' policy, dated 4/2018, the provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in containers . (H.) Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal and recorded . Expiration dating (Beyond-use dating): When the original seal of a manufacturers container or vial is initially broken, the container or vial will be dated. 1.) The nurse shall place a Date opened sticker on the medication and enter the date opened and the new date of expiration .		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement procedures and monitoring to ensure the assessment and clinical appropriateness of medication self-administration for one resident (Resident #55) of one resident reviewed. Findings include: Resident #55: On [DATE] at 11:31 AM, Resident #55 was observed sitting in a wheelchair in their room. An Albuterol inhaler (prescription fast acting rescue respiratory inhaler used to treat bronchospasms) was observed sitting on the Resident's overbed table. Resident #55 was observed self-administering two puffs, back-to-back without waiting one minute between puffs, of the albuterol inhaler medication without staff present. A sticker was present on the inhaler with Date Opened: [DATE]; Expired: [DATE] written on the inhaler. The built-in dose count number on the inhaler revealed there were 40 doses remaining in the inhaler. When queried regarding the date ([DATE]) written on the inhaler indicating the medication was expired and the built-in dose count number on the inhaler specifying there were 40 doses remaining, Resident #55 stated, Probably due to me not taking every dose. Resident #55 was asked how long they had the inhaler in their room and indicated they kept it in there but was unable to provide a date and/or state where they had gotten the inhaler from. Record review revealed Resident #55 was originally admitted to the facility on [DATE] with diagnoses which included Congestive Heart Failure (CHF), acute and chronic respiratory failure, and falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision/touching assistance for transfers and maximum assistance for bathing. A review of Resident #55's Electronic Medical Record (EMR) revealed the Resident did not have an assessment for medication self-administration. Review of Resident #55's Health Care Provider (HCP) orders and Medication Administration Record (MAR) in the EMR revealed the Resident had an order for Ventolin (Albuterol) HFA (Hydrofluoroalkane) Aerosol Solution (inhaler) 108 (90 Base) mcg (micrograms)/Act (actuation), 2 puff inhale orally three times a day for SOB (Shortness of Breath) The times on the MAR specified the inhaler was to be administered at 8:00 AM, 4:00 PM, and 8:00 PM. All doses were documented as administered by facility nursing staff. An interview was completed with the Director of Nursing (DON) on [DATE] at 11:44 AM. When queried regarding the facility policy/procedure related to resident self-administration of medications, the DON responded, It should be on the care plan if a Resident is able to self-administer medications. When queried regarding observation of Resident #55 having an expired albuterol inhaler, per written expiration date on the inhaler, on their overbed table and observation of self-administration, the DON verbalized Resident #55 should not have the medication on their overbed table and self-administer the medication without an assessment. The DON further confirmed that expired medication should be disposed of. Review of Resident #55's EMR with the DON revealed a care plan and/or care plan interventions pertaining to self-administration of medications including inhalers were not present. The DON verbalized understanding of the concern. A review of progress note documentation in Resident #55's EMR revealed no documentation of assessment for medication self-administration. Review of facility policy/procedure entitled, Self-Administration of Medications Management (Effective: [DATE]) revealed, If a resident requests to self-administer medication(s) that the interdisciplinary team will assess the resident to determine if it is clinically appropriate to honor the resident's choice, in order to maintain the resident's highest practicable level of functioning. A resident may only self-administer medications after the IDT has determined which medications may be safely self-administered. If resident requests self-administration of respiratory inhalants only, complete the Self-Administration Evaluation of (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respiratory Inhalants form. A periodic evaluation of the resident's ability to self-administer medication will be performed by the IDT, based on changes in the resident's medical and decision-making status. A physician's order will be obtained and recorded in the chart. The order also will include which specific medications can be kept at the bedside.		

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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 Activities of Daily Living (ADL) care, including clean bedding and bathing per preference, was provided to two residents (Resident #12 and Resident#55) of two residents reviewed. Findings include:Resident #12: On 6/8/26 at 12:10 PM, Resident #12 was observed in their room in bed. An interview was completed at this time. When queried if they need assistance to get out of bed and complete ADL care, Resident #12 verbalized that they do and revealed they are currently receiving therapy. Resident #12 was queried regarding showers and stated, I have only had one shower because of the time limit. When asked what they meant, Resident #12 stated, There is a queue and only one person to do it (showers). Resident #12 revealed the staff give them a bed bath when there is not enough time for a shower. Resident #12 was asked if they would rather have a bed bath or a shower and responded, Shower. Resident #12 expressed that before they became ill and went to the hospital, they took one to two showers a day a home. Record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses which included infection, nutritional deficiencies, and intestinal fistula (tunnel like connection between the intestine and another organ/skin) Review of Bathing documentation for the past 30 days Resident #12's Electronic Medical Record (EMR) revealed the task, Bathing: Wednesday/Saturday. Review of the documentation detailed the Resident received one shower on 6/7/26 and four bed baths on 5/24/26, 5/27/26, 5/30/26, and 6/6/26. On 6/9/26 at 10:41 AM, Resident #12 was observed in their room in bed. When queried if they had gotten washed up for the day or had their teeth brushed yet, Resident #12 stated they had not. When asked if they needed assistance brushing their teeth, the Resident responded that they do because they are unable to get to a sink themselves. Resident #12 then stated, I have to ask to brush teeth and revealed facility staff do not offer. When queried regarding their normal toothbrushing routine, prior to coming to the facility, Resident #12 revealed they always brushed their teeth first thing in the morning. Resident #12 stated, I would always brush my teeth and shower - (shower) in the morning and sometimes twice daily. A review of Resident #12's care plans revealed the Resident did not have a care plan specifically related to bathing/showers and/or individual bathing preferences. An interview was completed with the Director of Nursing (DON) on 6/9/26 at 2:45 PM. When queried regarding Resident #12's statements regarding there being a queue for showers due to only having one staff available for showers, the DON revealed the facility typically assigns one Certified Nursing Assistant (CNA) to provide showers, but other CNAs are able to provide showers. When queried why Resident #12 was not receiving showers when they stated they preferred showers, the DON responded that (Resident #12) should get a shower if that is their preference. Resident #12's bathing documentation was reviewed with the DON at this time. The DON verbalized understanding of the concern but did not provide further explanation. Resident #55: On 6/8/26 at 12:45 PM, an interview was completed with Resident #55 in their room. The Resident was in bed, positioned on their back with a food tray in front of them on the overbed table. The Resident's bed sheets were observed to have a significant and highly visible amount of a dried, dark red colored substance with the appearance of dried blood. When queried regarding the substance on their bed sheets, Resident #55 stated, I had a bloody nose last night. With further inquiry, Resident #55 revealed nursing staff assisted them to get their bloody nose to stop bleeding. At 12:49 PM, Certified Nursing Assistant (CNA) O entered Resident #55's room. As CNA O was leaving the room, they were stopped and queried regarding the dried blood on Resident #55's sheets. CNA O revealed they had not seen the blood when they were in the Resident's room previously and were not sure what it was from. Record (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review revealed Resident #55 was originally admitted to the facility on [DATE] with diagnoses which included Congestive Heart Failure (CHF), acute and chronic respiratory failure, and falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision/touching assistance for transfers and maximum assistance for bathing. Review of Resident #55's progress note documentation in the EMR revealed a Nurses Note dated 6/8/26 at 3:11 AM which specified, Resident with nosebleed, estimated blood loss 50 cc (cubic centimeter). An interview was completed with the Director of Nursing (DON) on 6/9/26 at 11:44 AM. When queried if resident bedding should be changed when visibly soiled, the DON confirmed it should. The DON was informed of interview with Resident #55 on 6/8/26 regarding their nose bleed during the night, documentation of nosebleed in the EMR, and observation of dried blood on the bed sheet. When asked why Resident #55's bed sheets still had blood on them at 12:45 PM when the nosebleed was documented in the EMR at 3:11 AM, the DON verbalized the Resident's bedding should have been changed and verbalized they would address the concern. Review of facility policy/procedure entitled, Activities of Daily Living (ADL), Supporting (Revised: March 2018) revealed, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). 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.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement procedures to ensure weight monitoring for two residents (Resident # 10 and Resident #50) of four residents reviewed for nutrition resulting in a lack of weight monitoring for residents with a known risk for nutrition deficiencies and with significant weight loss. Findings include: Resident #10: In an observation and Interview on 06/08/2026 at 11:43 AM, Resident #10 was observed at a table in the main dining room at the back windows seated up in a wheelchair with 3 other residents at his table. Resident #10 appeared thin with loose skin noted to his face and arms. Resident #10 stated that the food is OK, but nothing to brag about. In an observation and interview on 06/08/2026 at 11:48 AM, Resident #10 was observed to remove the lid to his hot tea beverage and able to drink by himself. Observed plates of pureed food items. Resident #10 was able to self-dine but needed encouragement to eat. Resident #10 stated that he has lost weight and that he does not know why. In an observation and interview on 06/08/2026 at 12:32 PM, the surveyor observed Resident #10 to have a pureed diet plate with pureed pot pie, mashed potatoes, butterscotch pudding with boost drink, and water thin consistency. Resident #10 prefers to just drink hot tea and not eat. Will check his weight log and dietary notes. Record review of Resident #10's dietary progress notes, dated 2/26/2026 at 2:08 PM, revealed: Resident has not been eating, writer tried talking to resident asking if he needed help eating, he stated he would do it if he knew how. Suggesting that resident go down to the main dining room so that he can get some assistance eating. Will keep observing to see if this helps with his eating. Dietary notes for Resident #10 dated 4/9/2026 at 2:20PM revealed the residents triggered for significant weight loss -6.9% x 30days. oral supplements added that magic cup one time daily, boost one time daily and House 2.0 supplement added 120ml daily. Dietary progress note dated 5/11/2026 at 9:02PM revealed admission weight back on 2/24/2026= 217.8 pounds. Weight on 4/5/2026= 196 pounds. Weight on 5/4/2026- 185.5 pounds and reweight obtained 5/7/2026- 184 pounds. Weight down 12 pounds over the past month and down 33.8 pounds (-15.6%) x 90 days which is significant month weight loss was not planned. Record review of Resident #10's care plans revealed an elderly male with medical diagnoses of Barrett's esophagus with dysplasia, heart failure, heart disease, gastro-esophageal reflux disease (GERD), nutritional deficiency, diabetes, muscle wasting, abnormal involuntary movements, dysphagia, memory deficit, depression, kidney failure, anemia and anxiety were a few of the diagnoses. Record review of the nutritional care plan revealed: Resident #10 is ordered and consumes a mechanically altered diet related to dysphagia. He has nutritional risk related to advanced age, diagnosis of encephalopathy, diabetes with insulin use, GERD, Barrett's esophagus, atrial fib, heart disease There were noted Registered Dietitian recommendations for 5/11/2026 noted in the focus (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Villa at West Branch		STREET ADDRESS, CITY, STATE, ZIP CODE 445 South Valley Street West Branch, MI 48661	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	section of the care plan. Record review of the Intervention section of the care plan noted that there were no added interventions after 3/5/2026 to a dress the weight loss. An interview and record review was conducted on 06/09/2026 at 10:39 AM with Registered Dietitian (RD) Q, who had been employed for three weeks at the facility. Prior to her arrival there was a hired RD and a contracted RD, but she has never met them. Record review of Resident #10's weight log with RD Q revealed: Starting weight on 2/24/26 of 217.8 lbs. On 03/23/2026, 30 days look back revealed Resident #10 weighed 204.5 lbs. which is a -6.11% Loss. On 05/04/2026, close to a 60 day look back Resident #10 weighed 185.5 lbs. which is a -9.29% Loss. Record review of a quarterly weight comparison revealed on 03/23/2026, the residents weighed 204.5 lbs. On 06/02/2026, the resident weighed 182.5 lbs. which is a -10.76% Loss. Registered Dietitian (RD) Q stated that she evaluated Resident #10's record yesterday, but had not seen him, I just reviewed his orders and increased his supplements on 6/4/2026. Resident #50: Record review revealed Resident #50 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral infarction (stroke) with resulting left sided hemiplegia and hemiparalysis (one-sided paralysis), dysphagia (difficulty swallowing), aphasia (impaired speech and communication), heart failure, and muscle wasting. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required moderate to total assistance to complete all Activities of Daily Living (ADLs) with the exception of supervision for eating. Review of Resident #50's Electronic Medical Record (EMR) weight documentation revealed the Resident weighed 143.5 lbs. on 5/11/26 and 135 lbs. on 6/4/26 which is a 5.92% Loss. There were three weights documented in Resident #50's EMR. The three weights included: - 5/11/26: 143.5 lbs. (pounds)- wheelchair scale - 5/15/26- 141.0 lbs. &ndash; wheelchair scale - 6/4/26 &ndash; 135.0 lbs. &ndash; wheelchair scale Review of documentation in Resident #50's EMR revealed Resident #50 was supposed to weighed weekly. An IDT: Care Conference note dated 5/8/26 at 12:26 PM specified, Dietary/Nutrition. Resident is tolerating diet. on a mechanical soft/nectar thick liquid. eats 25-50% of meals. Only have his first week's weight 143.5, will monitor weight weekly. A Dietary: Nutrition Assessment dated 5/24/26 was noted in Resident #50's EMR. The assessment included, Measurements. Ideal Body Weight: 154. Assessment. initially admitted to facility on 5/6/26. sent out on 5/13/26, before readmitting on 5/15/26. Wt following initial admission obtained 5/11/26 = 143.5. readmission wt on 5/15/26=141. Wt down slightly since initial admission, with BMI of 21.4 just below optimal range. Intake appears appropriate to support needs. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of progress note documentation in Resident #50's EMR did not include identification of weight loss. Review of Resident #50's EMR revealed a care plan entitled, (Resident #50) has potential for impaired nutritional status. diet with modified texture (mechanical soft) and thickened liquids (nectar thick) with meds also in place having known potential to impact nutritional status and/or wts (weights) (Initiated: 5/8/26). The care plan included the interventions: - Monitor and report to MD s/sx (signs/symptoms) malnutrition: emaciation (cachexia), muscle wasting, significant weight loss of 3lb in 1 week, 5% in 1 month, 7.5% in 3 months, or 10% in 6 months (Initiated: 5/8/26) - Registered dietitian to evaluate and make recommendations as indicated (Initiated: 5/8/26) An interview was conducted with Registered Dietician (RD) Q on 6/9/26 at 2:41 PM. When queried if Resident #50 was supposed to be weighed weekly, RD Q reviewed the Resident's EMR and confirmed they were. When asked if the Resident was supposed to be weighed weekly, RD Q confirmed they were. RD Q was asked why weights were not completed weekly and responded they did not know. When queried regarding the Resident's most recent weight on 6/4/26, RD Q reviewed the Resident's EMR and confirmed the Resident had lost more weight. When queried how much weight Resident #50 had lost, RD Q responded, 5.9 %. When asked, RD Q confirmed Resident #50's weight loss percentage was significant for a month period. RD Q then stated they would request a reweight for Resident #50. RD Q verified the concern with lack of weight monitoring and Resident #50's significant weight loss when asked. An interview was completed with the Director of Nursing (DON) on 6/10/26 at 9:18 AM. When queried regarding lack of weekly weights for Resident #50 and the Resident's 5.9% weight loss, the DON confirmed the Resident should have been weighed weekly due to being a new admission/readmission. Review of facility policy/procedure entitled, Weight Monitoring Guideline (Revised: June 7th, 2023) revealed, Purpose. the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance. Guideline: Residents will be weighed; documentation will be recorded. Upon admission and re-admission. Weekly for four weeks post admission and / or until the weight is determined to be stable. Monthly by the 10th of each month.		

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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 implement policies and procedures for the care and management of respiratory equipment and the administration of oxygen per Health Care Provider (HCP) orders for two residents (Resident #50 and Resident #55) of two residents reviewed. Findings include: Resident #50: On 6/8/26 at 9:25 AM, an observation of Resident #50's room was completed. A nebulizer machine was observed sitting on a stationary chair in the room at the foot end of the bed. The nebulizer administration set was connected and clear, visible fluid was present in the medication administration chamber. An oxygen concentrator was present with nasal cannula (NC) oxygen delivery tubing connected. The NC tubing was dated 5/28. Record review revealed Resident #50 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral infarction (stroke) with resulting left sided hemiplegia and hemiparalysis (one-sided paralysis), dysphagia (difficulty swallowing), aphasia (impaired speech and communication), heart failure, and muscle wasting. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required moderate to total assistance to complete all Activities of Daily Living (ADLs) with the exception of supervision for eating. Review of Resident #50's Medication Administration Record (MAR) in the Electronic Medical Record (EMR) revealed the Resident was receiving Ipratropium-Albuterol (DuoNeb) 0.5-2.5 mg (milligram)/3mL (milliliter) solution four times a day at 5:00 AM, 11:00 AM, 5:00 PM and 11:00 PM. The medication was documented as last administered on 6/8/26 at 5:00 AM. On 6/9/26 at 11:00 AM, Resident #50 was observed in their room, laying in bed with their eyes closed. Resident #50's NC was observed on the other side of the room laying on the floor near the concentrator. At 11:21 AM on 6/9/26, an interview and observation of Resident #50 was completed with Registered Nurse (RN) I. When queried regarding Resident #50's oxygen NC being on the floor, RN I picked up the oxygen tubing and placed it on top of the Resident's wheelchair but did not dispose of the tubing. When asked if the Resident was supposed to be receiving supplemental oxygen, RN I replied, They are trying to wean them off of it. A review of Resident #50's Electronic Medical Record (EMR) revealed the Resident had an active HCP order for administration of continuous oxygen via NC at 2 Liters (L) per minute. Further review of Resident #50's EMR revealed a care plan entitled, Resident has oxygen therapy r/t (related to) Emphysema, COPD (Chronic Obstructive Pulmonary Disease) (Initiated: 5/6/26). The care plan included the intervention, Oxygen Settings: O2 via nasal prongs @ 2L (Liters) continuous (Initiated: 5/7/26). Resident #55: On 6/8/26 at 12:45 PM, Resident #55 was observed in their room in bed. The Resident was receiving oxygen via NC at 5L/minute with humidification. An uncovered and uncontained Continuous Positive Airway Pressure (CPAP) mask was observed sitting on top of the dresser next to the Resident's bed along with multiple other items. A nebulizer administration mask was observed sitting in the open top drawer of the dresser beside the Resident's bed. The nebulizer administration set was connected with visible fluid and condensation noted in the medication chamber of the administration set. When queried, Resident #55 verbalized they utilized the oxygen therapy continuously as well as both inhalers and nebulizer treatments. Record review revealed Resident #55 was originally admitted to the facility on [DATE] with diagnoses which included Congestive Heart Failure (CHF), acute and chronic respiratory failure, and falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision/touching assistance for transfers and maximum assistance for bathing. Review of Resident #55's EMR revealed a care plan entitled, Resident has oxygen therapy r/t COPD (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Initiated: 1/6/26). The care plan included the intervention, (Resident) uses a CPAP. (Initiated: 1/26/26). Review of Resident #55's MAR revealed the Resident had PRN (as needed) orders for two different nebulizer treatments but had not received either treatment during the month of June 2026. An interview was conducted with the Director of Nursing (DON) on 6/9/26 at 11:55 AM. When queried regarding the facility policy/procedure related to storage and maintenance of nebulizers, the DON responded that the nebulizer should be rinsed and sat out to dry on a barrier to dry after each use. When queried regarding observations of fluid in the administration chambers of both Resident #50 and Resident #55's nebulizer administration sets, the DON confirmed fluid should not remain in the chamber and verbalized understanding of concern. When queried if Resident #50 is supposed to receive continuous supplemental oxygen via NC, the DON reviewed Resident #50's EMR and stated, Should be in place and confirmed the Resident had an active order for continuous oxygen therapy. The DON was informed of observation of Resident #50 having their oxygen in place as well as interview with RN I. When queried regarding RN I picking up the NC that was on the floor and sitting it on the Resident's wheelchair, the DON responded that the NC tubing should have been disposed of because it had been on the floor. Review of facility policy/procedure entitled, Oxygen Administration (Revised: October 2010) revealed, Policy. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 15. When O2 supplies is not in use, will store in designated storage bag to keep free from dust and dirt. A policy/procedure pertaining to nebulizer storage was requested but not received by the conclusion of the survey.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the accurate narcotic count and documentation of controlled substance usage for 1 of 4 medication carts. Findings include: Narcotic Reconciliation: In an observation and interview on 06/09/2026 at 11:26 AM with Registered Nurse (RN) I, an observation was made of the A-B Unit Medication Cart's controlled substance drawer. The Narcotic 'Controlled Substance Shift Inventory' form dated for 6/9/2026 noted 47 total narcotics. Observation and physical count of the A-B Unit medication cart noted 44 punch cards in the drawer, minus 1 used, equaled 45 and plus one in the medication room refrigerator equaled 46, The narcotic count was off by 1 missing narcotic for two consecutive 12-hour nursing shifts that were counted by facility nursing staff, but not found until RN I counted the narcotics with the state surveyor three times in attempt to locate the missing controlled substance. Observation, interview and record review was conducted on 06/09/2026 at 11:38 AM with the acting Director of Nursing (DON) in the A-B Unit Medication room [ROOM NUMBER], to review the Narcotic 'Controlled Substance Shift Inventory' form. Observed and counted 46 meds 44 meds in the cart, and 1 in the refrigerator which equals 45 controlled substances, one medication form competed or used up, for a total of 46 narcotics, and a count sheet stated total of 47. In an interview and record review of an 'Emergency Drug Kit Slip' undated for a discharged resident in room [ROOM NUMBER], Lorazepam 1mg/strength 2mg, there was no seal number, or lock number when closed, and no nurse's signature or date and time noted on the slip, but that the Ativan 2mg vial was not in the back up emergency kit. Observation, interview and record on 06/09/2026 at 12:51 PM with the Clinical Regional Director N counted the medication cart A-B Hall of 44 controlled substances in the narcotic drawer, Observation of Medication room [ROOM NUMBER] refrigerator had only one controlled substance, and she agreed that there is one missing. Regional Clinical N and DON agreed with the narcotic count of 45 total medications. They will continue with the investigation. In an interview on 06/09/2026 at 1:44 PM, the Clinical Regional Director N and the acting Director of Nursing (DON) stated that they found a narcotic sheet in the DON's office from empty cartridge yesterday by Registered Nurse (RN) G. It was not subtracted from the card count for 2 shifts, last night and this morning. So, the nurses did not catch that the card count was off for 2 shifts. The current process is that the oncoming and outgoing nurse count the total narcotics and then by each card. They missed it. They did not follow the complete narcotic process. Record review of the facility 'Controlled Substances' policy, dated 11/2020, revealed that the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of schedule II and other controlled substances. Implementation: (9.) Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together, they must document and report any discrepancies to the Director of Nursing Services. (10.) The Director of Nursing Services shall investigate and discrepancies in narcotic reconciliation to determine the cause and identify and responsibility parties and shall give the Administrator a written report of such findings.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement policies and procedures for personal in-room refrigerator food storage, monitoring and disposal for one resident (Resident #56) of one resident reviewed. Findings include: On 6/8/26 at 10:17 AM, Resident #56 was observed in bed with their eyes open. A small personal refrigerator was present in the room. An interview was completed at this time. When queried regarding the level of assistance they require for ADL care, Resident #56 revealed they do not get out of bed to use the bathroom and rarely leave their room. When queried regarding the fridge in their room, Resident #56 responded that the staff will get them items from it when they ask and indicated it mainly contained pop. Resident #56 provided permission to look in the refrigerator. A temperature log with temperatures and staff initials was present on the outside of the refrigerator. There were several cans of pop, a bottle of sauce, a package of cheese slices, cheese sticks, and an individual single serving container of sour cream in the fridge. Five cheese sticks (expired 11/2025) and an individual expired package of sour cream were expired and none of the food was dated when it was brought to the facility. When queried regarding the cheese sticks, Resident #56 revealed they love cheese and eat it frequently. When asked, Resident #56 was unable to provide a date of when they acquired the food. Record review revealed Resident #56 was admitted to the facility on [DATE] with diagnoses which included seizure disorder, anxiety, depression, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required maximum to total assistance to complete Activities of Daily Living (ADLs) with the exception of set-up for eating. An interview was completed with the Director of Nursing (DON) and Clinical Registered Nurse (RN) N on 6/9/26 at 12:12 PM. When queried regarding the facility policy/procedure related to food storage and disposal of expired foods in residents personal in-room refrigerators, the DON and RN N both verbalized that a facility staff member should ensure there are no expired food items in resident refrigerators. When asked what staff are responsible for monitoring and disposal of expired food items, the DON and RN N revealed they need to review the procedure. After being informed of the expired items in Resident #56's refrigerator, the DON responded they would address the concern. No further explanation was provided. A policy/procedure pertaining to resident in room refrigerators was requested at this time. Review of facility policy/procedure entitled, Personal Food Guideline (Effective: 3/12/18) revealed, It is our practice to support food brought for residents from outside sources. Food provided for a resident by family and visitors will be stored separately for facility food under safe and sanitary conditions. Safe food handling procedures will be shared with residents and facility members to ensure safe and sanitary food storage. and consumption. Food brought from outside sources. will be. labeled. Labeling will include. Received date, Use by date (no longer that 3 days), Staff members initials.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility failed to ensure that the daily posting of nurse staffing data was posted in a prominent place, included the hours worked of licensed and unlicensed nursing staff, and accurate documentation of staff numbers and actual hours worked, resulting in incomplete and inaccurate nurse staffing information. Findings include: On 6/9/26, the facility posted nursing staffing data was not observed near the visitor/front entrance of the facility nor in a visible area upon entering the Resident care area of the facility from the main entrance. An interview was completed with the Director of Nursing (DON) on 6/9/26 at 12:10 PM. When queried where the facility posted nurse staffing data was, the DON revealed they were interim at the facility and were unsure. After contacting another staff member, the DON indicated the staffing information was posted across from the Side Two nurses' station. The Side Two nurses' station was on the opposite side and end of the building from the visitor's entrance. The posting was dated 6/9/26 and included census and number of Registered Nurses (RNs), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNAs) for three shifts. All three shifts were filled out with the number of staff who were scheduled to work during that timeframe. The form did not include the actual hours worked for any shift but did include a section titled, Actual Hours worked (# and shift worked). Upon request, the Administrator provided the last 18 months of posted nurse staffing sheets. Review of the sheets revealed none of the sheets included the total number of actual hours worked for RNs, LPNs, and CNAs. A copy of the timeclock punch sheets for 6/8/26 were requested at this time. A comparison of the posted staffing sheet and timesheet clock ins for 6/8/26 was completed with Human Resources (HR) Director P. The total number of CNA staff did not match the timeclock punches provided. When queried why the sheets did not match, Director P responded that a CNA called in and was not taken off the posted staffing sheet. An interview was completed with the facility Administrator on 6/9/26 at 4:25 PM. When queried why the nurse staffing information was not posted in a visible area where all residents, staff, and visitors would be able to see it, the Administrator indicated they were advised to post it there previously. When queried regarding the posting not including the actual hours worked and total number of staff worked as required, the Administrator indicated they were unaware of the Federal Regulation requirements for the posting. When queried who is responsible for updating the posting if there are call ins and/or staffing changes, the Administrator revealed either they update it or a manager. When queried regarding the posted staffing information for 6/8/26, the Administrator did not provide further explanation. When queried regarding accuracy of posted staffing data, the Administrator verbalized understanding.		