STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235416	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sterling	500 School Road Sterling, MI 48659

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the safety of 1 resident (Resident #46) during 3 transfer's using a mechanical lift (wrong sling size used, it was too large) for 1 of 1 resident reviewed for mechanical (Hoyer) lift, resulting in the residents lower back and bottom hanging out of the large opening on the backside of the sling, verbalizing of discomfort and fear while being transferred. Findings Included:Resident #46:Review of the Face Sheet, Material Data Set/MDS dated 9/25, care plans dated 9/1/25, and admission nursing assessment dated [DATE], revealed Resident #46 was [AGE] years old, alert, admitted to the facility on [DATE], incontinent of bowel and bladder with a Foley urinary catheter in place, totally dependent on staff for his Activities of Daily Living/ADL's, and was mechanical lift for all transfers. The residents diagnosis included chronic kidney disease, chronic systolic and diastolic heart failure, anemia, dysphagia (difficulty swallowing), aphasia (communication deficit), BPH, depression and anxiety. Review of Resident #46's facility ADL care plan dated 8/29/25, stated Transfers: with 2 person assist and use of full mechanical lift and green sling. The green sling was the proper size for the residents height and weight. Review of the facility Accidents and Supervision policy dated 12/27/2023, stated Each resident will be assessed for accident risk and will receive care and services in accordance with their individualized care plan.Observation was made on 9/2/25 at 10:38 a.m., of Nursing Assistant's/CNA's N and P using a Hoyer lift to transfer the resident from his wheelchair to his bed to do peri care. The CNA's used a large (blue) Hoyer sling to hook him up to the lift. When he was in the air above his wheelchair, his bottom was falling out of the backside opening of the sling (it was too large for the resident). The right size sling (green) was sitting in his chair near his bed at the time. The CNA's did the residents peri care and continued to use the same (large blue) sling to transfer him back into his wheelchair for a shower. The resident was observed to be falling out of the backside of the opening of the sling for a second time.During an interview done on 9/2/25 at 10:45 a.m., CNA P stated he should be using the green one (the smaller green sling) and she pointed to the chair in the room with the green sling sitting in it.During a second observation done on 9/2/25 at 10:45 a.m., CNA/Shower Aide O had just brought the resident back from his shower and for a third time, he was lifted up from his wheelchair put back in his bed using the larger blue sling; he bottom was hanging through the large open area for a third time.During an interview done on 9/5/25 at 2:40 p.m., Resident #46 said he felt like he was going to fall when he was transferred on 9/2/25, and it hurt his lower back area.Review of the Hoyer sling measurement sheet (un-dated), revealed the height of the resident for the green sling was 50 in. and width was 35 in. of the opening in the backside, compared to the blue sling H-56 and W-37.Review of the facility Safe Lifting and Movement of Resident's policy dated 1/1/2022, stated Each resident is assessed through the Resident Assessment Instrument (RAI) and interdisciplinary team to determine lifting and movement assistance needs. At times, it is necessary to include the use of mechanical lifts to protect the safety and well-being of staff and residents, and to promote quality care. A sufficient number of slings, in the sizes required by residents in need, will be available at all times.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident dignity by 1) not ensuring a dignity bag was covering 1 resident's (Resident #46) urinary catheter bag, and 2) acknowledge 1 resident (Resident #19) when yelling for help for 2 of 13 residents reviewed for dignity.Findings Include: Resident #46: Review of the Face Sheet, Material Data Set/MDS dated 9/25, care plans dated 9/1/25, and admission nursing assessment dated [DATE], revealed Resident #46 was [AGE] years old, alert, admitted to the facility on [DATE], incontinent of bowel and bladder with a urinary catheter (Foley) in place, totally dependent on staff for Activities of Daily Living/ADL's, and required a mechanical lift for all transfers. The residents diagnosis included chronic kidney disease, chronic systolic and diastolic heart failure, anemia (low iron), dysphagia (difficulty swallowing), aphasia (communication deficit), BPH, depression and anxiety. Review of the facility Catheter Care policy dated 12/28/2023, stated Privacy bags are used to cover catheter drainage bags while in use. Observation of Resident #46 was made on 9/2/25 at 10:10 a.m.; staff were transferring the resident from the wheelchair to bed. The resident had a Foley catheter in place; however, it did not have a privacy bag covering it. The resident was put in bed, peri care was done, and he was then transferred back in his wheelchair. The facility had a catheter privacy bag velcroid to the bottom of the wheelchair, no privacy bag on his bed. When he was put back in the wheelchair, the catheter bag was not put in the privacy bag. Review of the residents Indwelling Catheter care plan dated 8/30/25, stated Privacy cover to catheter bag.During an interview done on 9/3/25 at approximately 9:20 a.m., Infection Control Nurse, RN B said the did use urinary catheter privacy bags and he should have had one (on his bed) for his catheter. During an interview done on 9/5/25 at 12:52 p.m., MDS Nurse/Unit Manager, RN F stated They (staff) usually have one on the wheelchair (urinary catheter privacy bag) and one on the bed; they need one (privacy bag). Nurse Manager F said a Foley catheter bag should be kept in a privacy bag for dignity. During an interview done on 9/4/25 at 9:31 a.m., Social Worker, E stated They (a Foley catheter bag) should be in a privacy bag; in bed too. The resident required a catheter privacy bag on his wheelchair and his bed. During a second observation of the resident done on 9/5/25 at 2:15 p.m., Resident #46 was sleeping in bed, with his urinary catheter bag not in a privacy bag; the privacy bag was hanging on the opposite side of his bed. Also, the resident had a very strong urine odor at the time; his room smelled of urine. When this surveyor interviewed MDS/Unit Manager F on 9/5/25 at 2:25 p.m., she stated We are better than that. Nurse Manager F educated staff again immediately. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Resident Dignity policy dated 10/26/2023, stated It is the practice of this facility to protect and promote resident rights and treat each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Maintain resident privacy. Resident #19 On 9/2/25 at 1:51 PM, Resident #19 was observed sitting in a wheelchair in their room. Upon entering the Resident's room, a prevalent and strong bowel movement odor was noted. The odor became stronger closer the Resident. When queried if they are treated in a respectful and nice manner by facility staff, Resident #19 replied, No. When asked how the staff did not treat them in a nice and respectful manner, Resident #19's response was unable to be completely understood. Resident #19 was then asked if they are able to use the bathroom by themselves or if they need assistance from staff and revealed they need assistance from staff. Resident #19 verbalized they were waiting for staff to help them because they had a bowel movement. When asked if staff knew they had a bowel movement and were waiting for assistance, Resident #19 revealed they asked for help and were told to wait in their room. At 2:24 PM on 9/2/25, Resident #19 was heard yelling, I need changed, I need changed from the hallway of the facility. Multiple staff members, including Certified Nursing Assistants (CNAs) and a Nurse were observed walking past the Resident's room and not stopping to acknowledge them while they were yelling for assistance. At 2:25 PM on 9/2/25, Resident #19 self-propelled themselves to the doorway of the room while yelling out for assistance. The facility staff in the hallway did not acknowledge the Resident. Resident #19 proceeded to propel themselves out of their room and down the hallway past staff members. Upon approaching the Resident, the odor of bowel movement remained intense. Record review revealed Resident #19 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's disease, intellectual disabilities, bipolar disorder, seizures, and cerebral palsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required substantial to maximal assistance with toileting hygiene. Review of Resident #19's care plans revealed a care plan entitled, Resident has an ADL self-care performance deficit related to Alzheimer's Disease. Does not use call light appropriately to ask for assistance related to cognitive deficits. Staff to anticipate and meet needs (Initiated: 10/24/23; Revised: 6/18/24). The care plan included the intervention, Toileting: 2 person assist to using grab bars. Blue pads on bed (Initiated: 10/24/23; Revised: 11/11/24).

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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 appropriate use and administration of insulin with an insulin pen per manufacturer recommendations and professional standards of practice for one (#35) of two residents reviewed for insulin administration. Findings include: Resident #35:A medication pass observation for Resident #35 was completed with Licensed Practical Nurse (LPN) W on 9/5/25 at 8:32 AM. LPN W was observed preparing the Resident's medications including Lantus Solostar Insulin Pen (long-acting insulin in a prefilled insulin pen with a turn dial on the bottom of the pen to select the dose for administration). LPN W entered the Resident's room, administered their oral medications and then proceeded to administer the insulin using the Solostar Pen in the Resident's right upper abdomen. LPN W held the Solostar Pen in place for five seconds, including the time the administration injection button on the bottom of the Solostar Pen was depressed, prior to removing the pen from Resident #35's abdomen.An interview was completed with LPN W after exiting Resident #35's room. When queried how long they are supposed to hold the insulin pen in place after the dose has been administered, LPN W stated, Five seconds. When queried if holding for five seconds was the facility policy/procedure, LPN W verbalized the insulin pen has to be held in place, so the medication is absorbed. When asked if the time the injection button was held down counted towards the time the pen had to be held in place, LPN W did not respond. An interview was completed with the facility Administrator on 9/5/25 at 9:30 AM. The Administrator was informed of SoloStar insulin pen administration by LPN W and concern related to not holding the pen in place for 10 seconds and the potential for the Resident to not receive the entire dose. The Administrator verbalized understanding. A review of Lantus. How to use your Lantus SoloStar pen ([NAME]-Aventis, 2022), revealed, A step-by-step guide to using your Lantus SoloStar pen. Step 5. Inject Your Dose. Keep the pen straight, insert the needle into your skin. Use your thumb to press the injection button all the way down. When the number in the dose window returns to 0 as you inject, slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose.) Release the button and remove the needle from your skin.

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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 interview and record review, the facility failed to implement and operationalize procedures to ensure follow-up assessment and monitoring of abnormal laboratory testing results of medications with for one (#19) of five residents reviewed. Findings include:On 9/2/25 at 1:51 PM, Resident #19 was observed sitting in a wheelchair in their room. A fall mat was observed on the floor next to the left side of the Resident's bed and they had a raised edge mattress in place on their bed. When queried if they had fallen at the facility, Resident #19 did not respond. Record review revealed Resident #19 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included epilepsy, Alzheimer's disease, intellectual disabilities, bipolar disorder, and cerebral palsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required substantial to maximal assistance to complete Activities of Daily Living (ADLs) with the exception of eating and oral hygiene. The MDS further revealed the Resident had two falls, one with no injury and one with injury. Review of Resident #19's Health Care Provider (HCP) orders and Medication Administration Record (MAR) revealed the Resident was receiving the following medications with therapeutic levels:- Keppra (Levetiracetam) 1000 milligrams (mg) every 8 hours related to epilepsy (Start Date: 2/1/25) - Depakote (Valproic Acid- medication used to treat seizures and bipolar disorder) 500 mg three times a day due to epilepsy (Start Date: 6/15/23) Further review of Resident #19's HCP orders revealed the following orders for and/or related to laboratory testing:- Keppra level, Valproic acid level, hepatic (liver function), CBC (Complete Blood Count) . baseline and q (every) 6m (6 months) (Ordered: 12/22/23)- Send resident to (Hospital) for Keppra eval STAT for Keppra Level (Ordered: 1/29/25)- Send to ER for eval d/t abnormal Keppra level (Ordered: 1/30/25)- Repeat Keppra level on 2/6/25 (Ordered: 2/5/25) Review of Resident #19's Electronic Medical Record (EMR) revealed a care plan entitled, Resident has an impaired neurological status related to Alzheimer's Disease. epilepsy, seizure disorder. (Initiated: 10/24/23: Revised: 10/25/23). The care plan included the interventions:- Administer medications and treatments as indicated by orders (Initiated: 10/24/23) - Keep resident safe during seizures. Clear hard/sharp objects away from resident. Place resident on their side to keep airway clear. Notify Nurse if seizure activity occurs (Initiated: 10/24/23) - Observe labs/diagnostic testing per orders (Initiated: 10/24/23) A second care plan entitled Resident is at risk for falls/injury related to bladder incontinence, bowel incontinence, decreased strength and endurance, functional problems, generalized weakness, high risk of falls, history of falls, history of self-transfers, impaired cognition with decreased safety awareness, inability to use call light due to confusion, medication(s), needs assistance with ADLs. (Initiated and Revised: 10/24/23). The care plan included the interventions,- 2/22/25: Alert nursing staff when resident appears to be having seizure activity (Initiated: 2/24/25) - 3/19/25: Keppra (anti-seizure medication with a therapeutic range) Level (Initiated: 3/25/25). A review of the facility provided Incident and Accident (I and A) forms for Resident #19 revealed the Resident had two falls related to seizure activity since the last annual survey. A review of facility documentation for the falls related to seizure activity detailed the following: - 2/22/25 at 3:30 PM: Resident #19 was in the Activity room, sitting in their wheelchair, when they were observed starting to have a seizure by Activity Staff T. The Resident fell out of their wheelchair and hit their forehead. Activity Staff T paged overhead for assistance from nursing staff. Registered Nurse (RN) Q and Certified Nursing Assistance (CNA) R responded to the overhead page. RN Q assessed Resident #19, and the Resident was assisted back into their wheelchair and returned to their room by RN Q and CNA R. Resident #19 received Diazepam (Valium- controlled medication used as an emergency medical treatment for seizure activity) 20 milligrams (mg) rectally due to the seizure which was effective. The notes included on the I and A form detailed the intervention implemented following the seizure and fall included, asking for assistance from the nurse when seizure activity noted and neuro (monitoring) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order put in place. - 3/19/25 at 4:45 PM: Resident #19 was observed laying on the floor in their room in front of their wheelchair having a seizure by CNA U. CNA U called Licensed Practical Nurse (LPN) V to the room. The Resident was assessed, assisted into bed, and rectal Diazepam was administered. The immediate intervention implemented following the seizure and fall was Keppra level to be drawn at next lab draw.Review of progress note documentation in Resident #19's EMR revealed the following additional information: - 12/29/24 at 11:35 AM: Activity Progress Note. Res. was up in wheelchair in activities started to have seizure activity CNA came and got the nurse. took to room and gave seizure med rectally. - 1/29/25 at 11:26 PM: Nurses' Notes. Resident had been sent to the ER d/t (due to) Keppra level being 109.6 at 8 pm this day on the afternoon shift. - 1/30/25 at 3:38 PM: Nurses' Notes. Provider notified that resident had returned to facility. New order to hold Keppra and to draw Keppra levels X 3. - 2/11/25 at 8:07 PM: Nurses' Notes. Resident's Keppra level reviewed with (Physician A). Continue same dose. - 3/19/25 at 7:41 PM: Resident observed lying on fall mat in front of w/c with eyes rolling back in head. Resident appeared to be attempting to raise head up and then it would suddenly drop as is usual for them when having a seizure. Resident laying on his right side with head toward bed. W/c brakes were not locked. Resident assessed for injury - no bruising, swelling, abrasions observed. Joints and long bones palpated with no abnormalities and resident denying pain. Resident assisted to bed via Hoyer (mechanical lift) Resident given Diazepam as ordered. No further seizure activity. NP (Nurse Practitioner) notified, no new orders. - 3/24/25 at 2:50 PM: Nurses' Notes. Resident refused blood draw. Physician aware. Reattempt with next draw. - 5/11/25 at 9:19 PM: Nurses' Notes. Resident with seizure activity this afternoon at 4pm. Resident has been resting in bed since. Resident chooses not to eat dinner. Meal alternatives and nutrition shakes provided, however resident continued to choose not to eat. - 5/23/25 at 6:31 PM: Nurses' Notes. At 3pm resident was observed with seizure activity - head dropping with eyes rolling back and long pauses while speaking. Resident assisted into bed and Diazepam given as per order. At 3:45pm resident began yelling out again. This nurse went to room and observed resident on the fall mat next to bed. - 6/12/25 at 5:42 PM: Nurses' Notes. Resident noted to be having seizure activity including head dropping, eyes rolling back, pauses while speaking and brief periods of non-responsiveness while in the dining room at 5pm. Resident assisted back to his room and given Diazepam rectally as ordered. No further seizure activity noted. Physician notified. A review of Resident #19's laboratory testing in the EMR revealed the following: - 2/11/25: Levetiracetam, Serum: 55.2 ug/mL (micrograms per milliliter) . Reference range: 3.0 to 60.0 ug/mL. - 3/25/25: Levetiracetam, Serum: 89.9 (elevated) ug/mL (micrograms per milliliter) . Reference range: 3.0 to 60.0 ug/mL. The laboratory results had an illegible signature and date which appeared to be 6/12/25 on the bottom of the scanned page. - 7/8/25: Valproic Acid 69 ug/mL [Reference range: 50.0-100.0 ug/mL] . Levetiracetam, Serum. Pending. An interview was completed with the Administrator and Acting Director of Nursing (DON) RN B on 9/5/25 at 12:35 PM. The Administrator and DON were queried regarding Resident #19's seizure and fall on 2/22/25 and both indicated they would need to review the Resident's EMR. When asked about the intervention of Alert nursing staff when resident appears to be having seizure activity following the Resident's fall on 2/22/25, the Administrator and RN B confirmed that was the intervention implemented. When asked why that intervention was not already in place, as the Resident had a history of seizures, the Administrator indicated it was intended to be a signs prior to a seizure occurring and stated, We failed that (intervention). Should have been more specific. When queried regarding the Resident's valproic acid levels were last drawn, RN B indicated they would need to review the Resident's EMR. When asked why the levels were not drawn following the seizure, RN B verbalized labs are completed per HCP orders. When queried regarding the Resident's seizure and fall on 3/19/25, RN B reviewed Resident #19's EMR and revealed the intervention was to draw a Keppra level. When asked why the Keppra level was not drawn until 3/25/25, the Administrator verbalized that the Resident may have refused to have their blood drawn at the next draw. Resident #19's lab testing results dated 3/25/25 were reviewed with RN B and the DON at this time. When queried regarding follow up to the the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elevated serum Keppra level such as repeat laboratory testing and/or dosage adjustment, RN B reviewed Resident #19's EMR and stated, There was no redraw and no dose adjustment. RN B then stated, The doctor signed the lab results. When asked who signed the laboratory result and the date it was signed, RN B responded it was the HCP's signature, and the date was 4/12/25. When queried if nursing staff contacted the HCP regarding the elevated level and advocated for a redraw of the lab, RN B reviewed the EMR and responded that there were no notes reflecting nursing staff contacted the Health Care Provider. When asked why the HCP was not notified, further explanation was not provided. RN B and the Administrator were then asked to review Resident #19's labs dated 7/8/25. When queried what the Resident's serum Keppra level was on that date, RN B confirmed the results scanned in the EMR indicated the Keppra level was pending and they did not know the result. The Administrator indicated they would have someone contact the lab to obtain the result now. When asked why no one contacted the lab to obtain the results, RN B was unable to provide an explanation. With further inquiry regarding the Resident's level being elevated in March, not redrawn until July and the facility still not having the results in September, both RN B and the Administrator verbalized understanding of the concern. The Administrator verbalized a new process/procedure would be implemented pertaining to laboratory testing and follow up of abnormal results.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Enhanced Barrier Precautions/EBP were used, and handwashing was done after glove removal for 1 resident (Resident #46) of 13 resident's reviewed for handwashing and proper personal protective equipment usage, resulting in the protentional for cross contamination, resident and staff illness and increased antibiotic use.Findings Include: Resident #46:Review of the Face Sheet, Material Data Set/MDS dated 9/25, care plans dated 9/1/25, and admission nursing assessment dated [DATE], revealed Resident #46 was [AGE] years old, alert, admitted to the facility on [DATE], incontinent of bowel and bladder with a Foley urinary catheter in place, totally dependent on staff for his Activities of Daily Living/ADL's, and was mechanical lift for all transfers. The residents diagnosis included chronic kidney disease, chronic systolic and diastolic heart failure, anemia, dysphagia (difficulty swallowing), aphasia (communication deficit), BPH, depression and anxiety.Review of the residents facility EBP care plan dated 8/29/25, stated Utilize Enhanced Barrier Precautions when providing high contact resident care activities (transferring, personal hygiene, changing linens, urinary catheters).Observation was done on 9/2/25 at 10:38 a.m., of Nursing Assistant's/CNA's P and N transferring Resident #46 from wheelchair to bed and doing peri care. The resident had signage on the room door indicating EBP was to be used with all care (gloves, and gown) due to him having a urinary catheter in place. Neither CNA P nor N put any gown on due to EBP precautions; the plastic bin containing the EBP was just inside the room by the door. CNA N changed the resident, did peri care and catheter care, while CNA P assisted with resident positioning. When CNA N was done with care, she walked to the residents bathroom, removed her soiled gloves and put another pair on; she did not wash her hands after removing her gloves. CNAP assisted making his bed after a second transfer with her soiled gloves still on. CNA/Shower Aide O came in the room, did not gown up and after assisting with the transfer, removed her soiled gloves, threw them in the trash, opened the door touching the door knob and left the room, taking the resident to the shower room. Shower Aide O did not wash her hands after removing her gloves.Review of the facility Personal Protective Equipment policy dated 12/7/2023, stated Wear gowns to protect arms, exposed body areas, and clothing from contamination with blood, body fluids, and other potentially infectious material.Review of the facility Enhanced Barrier Precautions (EBP) policy dated 3/26/24, revealed resident's with urinary catheter's will have EBP equipment (gowns, gloves, mask) available for high-contact care activities which include, peri care, prosomal hygiene and handlining linens.Review of the facility Glove Use policy (un-dated), stated When task for which gloves are used is completed, remove gloves, turning inside out, and wash hands.Review of the facility Hand Hygiene dated 12/13/23, stated The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure nurse staffing information was posted in a clear and prominent place readily accessible to residents and visitors for all 39 facility residents. Findings include:The facility nurse staffing information was attempted to located in the facility on 9/2/25, 9/3/25, and 9/4/25 without success.An interview was completed with the facility Administrator on 9/4/25 at 1:09 PM. When queried where the facility nurse staffing data is posted, the Administrator proceeded to go to the front entrance of the facility and remove a clipboard from a bin on the wall. When queried if that is where the daily staffing is always kept, the Administrator responded it was. When queried regarding the information not being in a clear and prominent area for residents and visitors to view, the Administrator revealed they were unaware the staffing information had to be in a clearly visible area. The Administrator verbalized they would order something to be able to post the nurse staffing information in a clearly visible area.