STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235429	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at the Bay	1500 Spring St Petoskey, MI 49770

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to complete assessments to ensure safe self-administration of medication for three Residents (R60, R61, and R230) of 18 residents reviewed for right to self-administer medications. Findings include: Resident #60 (R60) The medical record for R60 revealed an admitted to the facility on [DATE] with a primary diagnosis of respiratory failure. R60 had a Brief Interview Mental Status (BIMS) assessment score of 9 out of 15 indicating moderately impaired cognition. On 5/21/25 at 9:10 AM, an observation was made of R60 asleep and resting in their bed. R60 had a medication cup on their bedside table with six oral pills and a clear plastic cup with a light brown substance which measured approximately 6 ounces. On 5/21/25 at 9:18 AM, an interview was conducted with Licensed Practical Nurse (LPN) O after they entered R60's room. LPN O was asked how long the medications had been sitting on R60's bedside table and if R60 had a physician order to self-administer medications. LPN O replied, The medications have been there for ten or fifteen minutes. I am not sure if (R60) has an order to self-administer. I would have to check. LPN O was asked what kinds of medications were left in the medication cup on the bedside table and replied, I would have to review the medication administration record to be exact. Review of R60's medication administration record (MAR) entry, dated 5/21/25 revealed the following medications were signed out at approximately 8:35 AM: - Cholecalciferol (vitamin D) 1000 units, one tab. - Multi-vitamin, one tab. - Amlodipine (blood pressure medication) 5 milligrams (mg), one tab. - Acetaminophen (tylenol) 650 mg, two tabs. - Tramadol (controlled pain medication) 50 mg, one tab. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- House high calorie supplement (protein liquid identified in the clear plastic cup), 6 ounces. During a follow-up interview on 5/21/25 at 11:40 AM, LPN O indicated there was no assessment completed for R60 to self-administer medications, and stated there was also no physician order to self-administer medications. Review of R60's most recent quarterly nursing evaluation, dated 12/21/24, revealed under Section N: Preferences #4: Self-medicates/desires to self-medicate? No. Resident #61 (R61) The medical record for R61 revealed an admitted to the facility on [DATE] with a primary diagnosis of dementia. R61 had a BIMS assessment score of 8 out of 15 indicating moderately impaired cognition. On 5/20/25 at 11:27 AM, an observation was made of R61 lying in their bed. R61 had a medication cup on their bedside dresser that contained a white power substance. R61 was asked about the white powder inside the medication cup and just shrugged their shoulders. On 5/20/25 at 12:14 PM, an interview was conducted with Certified Nurse Aide (CNA) H regarding the contents of the medication cup in R61's room. CNA H replied, I don't know. It could be antifungal powder. I bet midnights [the midnight shift nurse] left it there though. On 5/20/25 at 12:20 PM, an interview was conducted with LPN D who was asked about the medication cup with the white powder on R61's bedside dresser and replied, I am not sure. It could be a couple of different things. I would have to review (R61's) treatments. LPN D was asked if R61 had an assessment to self-administer medications or if the medication cup containing the white powder should be left on R61's bedside dresser and replied, No, it should not be there, and I don't think there is an assessment. Review of R61's most recent quarterly nursing evaluation, dated 12/30/24, revealed under Section N: Preferences #4: Self-medicates/desires to self-medicate? No. Review of R61's treatment administration record (TAR), dated 5/21/25 revealed no ordered skin treatment/prevention such as creams or powders. Resident #230 (R230) The medical record for R230 revealed an admitted to the facility on [DATE] with a primary diagnosis of heart failure. R230 had a BIMS assessment score of 8 out of 15 indicating moderately impaired cognition. On 5/20/25 at 12:02 PM, an observation was made of R230 lying in her bed resting. R230 was asked how they were doing and replied, It's too early to tell. R230 was asked about the nystatin cream on their bedside dresser and replied, I use that daily. The hospital sent it with me, so I had some to use. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 12:22 PM, an interview was conducted with LPN D who was made aware R230 had a tube of nystatin cream on their bedside dresser and replied, As far as I know (R230) does not have an assessment to self-administer medications. I will have to check to see if there is even an order for that. Review of R230's most recent quarterly nursing evaluation, dated 5/19/25, revealed under Section N: Preferences #4: Self-medicates/desires to self-medicate? No. Review of R230's MAR/TAR, dated 5/19/25 through 5/21/25 revealed no physician order for the nystatin cream. On 5/21/25 at 12:15 PM, and interview was conducted with the Director of Nursing (DON) who was asked if any of the current residents in the facility had a physician order to self-administer medications and replied, No. The DON was asked if medications, including controlled substances, should be left at the bedside unattended for residents to take at their leisure and replied, No. The DON was asked if all medications needed a physician order and replied, Yes. Review of policy titled, Self-Administration of Medications, dated 2/2021, read in part, Policy Statement: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation: 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self -administering medications is safe and clinically appropriate for the resident . 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status . 5. Residents who are identified as being able to self-administer medications are asked whether they wish to do so . medications are stored in a safe and secure place, which is not accessible by other residents . 9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party . Review of policy titled, Medication Storage, dated 05/2022, read in part, Policy: The facility shall store all medications and biologicals in a safe, secure, and orderly manner. General Guidelines: 1. 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 . 5. Medications for external use, as well as poisons, shall be clearly marked as such . Review of policy titled, Controlled Substance Accountability Guideline, no date, read in part, .Controlled Substance Administration. Chapter 4: Controlled substances are administered with great care .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 49397 Based on interview and record review, the facility failed to ensure accurate advanced directive information for four Residents (#17, #57, #62, #278) of four residents reviewed for advance directives (legal document that allows a person or their representative to identify medical care preferences if they should be unable to do so). Findings include: Resident #17 (R17) On 5/20/25 at 12:38 PM while conducting a review of R17's Electronic Medical Record (EMR), the responsible party was identified as a legal guardian. R17's (State)-POST (Physician Orders for Scope of Treatment) advance directive indicated full code/full treatment was to be administered in the event of a life threatening emergency. The form was signed by R17, instead of their legal guardian. Resident #57 (R57) On 5/20/25 at 1:51 PM, during a review or R57's EMR, the admission record indicated R57 had a designated legal guardian. A (State)-POST advance directive signature dated 3/24/25 was written as a V.O. (Verbal Order) by a Licensed Practical Nurse for R57's guardian's acknowledgment of the document. No other signatures were present as witnesses. Resident #62 (R62) A review of R62's EMR on 5/20/25 at 1:16 PM revealed there was a Designated Power of Attorney (DPOA, legal document that allows a person to appoint someone to make financial and/or health decisions on their behalf, even if the person becomes incapacitated) for healthcare in place. R62 was deemed by two physicians to be unable to participate in medical treatment decisions on 9/27/24. R62's (State)-POST advance directive for full code/full treatment was signed by R62 on 10/29/24, instead of their DPOA. Resident #278 (R278) On 5/21/25 at 1:00 PM, a review of R278's admission record indicated there was a designated guardian as their responsible party. On 5/21/25 at 1:12 PM, the EMR was reviewed and a record was found for a (State)-POST advance directive which indicated R17 was to be a full code. The document had a verbally acknowledged signature for R17's guardian on 5/8/25. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/25 at 3:10 PM, during an interview, MDS (Minimum Data Set) Nurse C stated, since the facility does not currently have a social worker it has been a team effort to take on social services' roles. The MDS nurse stated all staff are responsible for getting advance directives completed and signed by the residents. The MDS nurse stated residents can sign unless they have a been deemed incapacitated, and/or have a guardian. Review of the facility's policy titled Advanced Directives and Care Planning Guidelines indicated in part G .ii Define and clarify medical issue, review the resident's condition and existing choices and present information regarding relevant health care issues to the resident or resident representative as appropriate to determine continuation or modification of choices of care. iii Evaluate the resident for decision-making capacity and based on evaluation if the resident is determined not to have decision-making capacity, facility staff will invoke the health care agent or legal representative . According to the Department of Health and Human Services Policy and Planning Administration Michigan Physician Orders For Scope of Treatment, June 10, 2022 .Completing the MI-POST . (2) A valid MI-Post must be signed by both: (a) The patient, or the patient representative. (b) The attending health professional. Any verbal or telephone signatures are for medical orders only and must then be signed by the attending health professional within 10 calendar days. MI-Post Approved FAQ (Frequently Asked Questions) .Who can sign the MI-POST on behalf of the patient? The MI-POST must be signed by the person for whom it is completed. If he/she lacks capacity (or competency), a patient representative may sign the form. The patient representative refers to the Patient Advocate documented in a Designation of Patient Advocate/Durable Power of Attorney for Healthcare (DPOA-HC) form or, if no DPOA-HC has been executed, a court-appointed guardian with authorization to make healthcare decisions. The MI-POST form should reflect the patient's wishes .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview and record review the facility failed to follow their grievance procedure and make prompt efforts to resolve grievances regarding complaints of missing items for three Residents (#5, #11 and #22) of three residents reviewed for inaction of grievances. Findings include: Resident #5 (R5) The medical record for R5 included a face sheet indicating an original admitted [DATE]. The Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15 indicating intact cognition. On 5/22/25 at 10:14 AM, R5 complained she had many things that were missing. R5 said, I am missing two black tops, and I told staff but (heard) nothing. I guess the tops just disappeared. I am also missing an orange top. R5 stated she has tried to follow up and has asked staff about the items, but she has been told we don't know. R5 stated, Sometimes it gets upsetting. During an interview on 5/22/25 at 10:15 AM, Registered Nurse Consultant (RN) L discussed grievances of missing items and reviewed the facility grievance log back through 2023. There was no record of any logged concerns for missing items for R5. During an interview on 5/22/25 at 10:23 AM, RN E stated she remembered R5 missing some clothing. RN E said, Yes, I filled out a missing item slip (for the items). I feel like that was a while back. Resident #11 (R11) The medical record for R11 included an MDS assessment dated [DATE] indicating an admitted [DATE] and included a BIMS assessment score of 11 out of 15 indicating moderately impaired cognition. During an interview on 5/21/25 at 2:06 PM, RN B stated he had overheard R11 declaring she was missing a sweater. RN B said, There seems to be a lot of missing items lately. Resident #22 (R22) The medical record for R22 included a face sheet indicating an admitted [DATE]. The MDS assessment dated [DATE] included a BIMS assessment score of 14 out of 15 indicating intact cognition. During an interview on 5/20/25 at 1:01 PM, R22 stated the facility had lost several items of her clothing and they were still looking for them. R22 explained, I have notified several staff members that I am missing gray sweat pants, a blue sweatshirt and a brown long sleeve shirt. During an interview on 5/21/25 at 3:03 PM, RN Consultant L reviewed the facility grievance log and did not find any grievances for the missing items reported by R11 or R22. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/25 at 10:01 AM, the Interim Environmental Services Supervisor (Staff) M acknowledged she was aware R22 was missing a pair of pants and a hoodie and was keeping an eye out for them. Staff M stated, We have not yet seen them, but it has been a while. Staff M did not have a record of the missing items for R22 but stated they had been verbally reported. Staff M discussed the missing item process stating sometimes there was a written report describing missing items and then a search would begin. Staff M said, If we are struggling to locate items, we talk to administration. The facility policy titled Grievance Guidelines dated effective 11/28/2017, read in part, It is the practice of this facility that each resident has the right to voice grievances to the facility or other agency or entity that hears grievances . The facility will ensure prompt resolution to all grievances, keeping the resident and resident representative informed throughout the investigation and resolution process. The facility grievance process will be overseen by the Administrator/designee who will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations .communicate with residents throughout the process to resolution and coordinate with other staff .The facility will provide a mechanism for filing a grievance/complaint .and will provide an ongoing system for monitoring and trending grievances and complaints. The policy included a GRIEVANCE/CONCERN FORM, a GRIEVANCE INVESTIGATION form and a GRIEVANCE RESOLUTION RESPONSE form. No grievance forms included in the above policy were found or presented for the missing items described by R5, R11, or R22.

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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. 40383 Based on interview and record review, the facility failed to adhere to the applicable components of the process for transferring or discharging residents including the notice of bed-hold policy and the written notice of transfer or discharge to both the resident, resident's representative, and the representative of the Office of the State Long-Term Care (LTC) Ombudsman, with the reason for a transfer for five Residents (#1, #42, #50, #54, and #75) of five residents reviewed for transfers out of the facility. Findings include: Resident #50 (R50) During an interview on 05/20/25 at approximately 12:20 AM, R50 stated she had been transferred out to the hospital a while ago. The medical record for R50 revealed three transfers dated 12/16/24, 12/23/24, and 1/4/25. The medical record did not indicate a written notification of transfer, or a bed hold policy was given to R50 or a responsible party for any of the transfers. Resident #54 (R54) During an interview on 05/20/25 at approximately 11:50 AM, R54 indicated he had been transferred out to the hospital during his stay at the facility although he was not sure of the date. The medical record for R54 revealed a transfer to the hospital on 1/9/25 with a readmission on 1/13/25. The medical record did not indicate a written notification of transfer, or that a bed hold policy was given to R54 or his responsible party. On 05/21/25 at 3:41 PM, the Director of Nursing (DON) stated she did not believe there was a system in place to send written transfer notifications to the resident and resident representative. Further follow up with the Regional Clinical Consultant Registered Nurse (RN) L revealed no documentation of bed hold policy presentations or written notification of transfers had been given to transferred residents or their responsible parties. During an interview on 5/22/25 at 10:45 AM, Clinical Consultant RN L confirmed there was not an Ombudsman log to alert the Office of the State LTC Ombudsman of the transfers. 45123 Resident #1 (R1) During an interview on 5/20/25 at 11:32 AM, R1 indicated they had been sent out to the local hospital during their stay at the facility but were unsure of the exact date. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The medical record for R1 revealed a transfer to the hospital on 12/7/24 with a readmission on 12/9/24. The medical record did not indicate a written notification of transfer or a bed hold policy was given to R1 or their responsible party. Resident #42 (R42) During an interview on 5/20/25 at 12:04 PM, R42 stated that they had been admitted to the local hospital for pneumonia a couple months ago. The medical record for R42 revealed two transfers dated 2/23/25 and 3/18/25. The medical record did not indicate a written notification of transfer or a bed hold policy was given to R42 or their responsible party. Resident #75 (R75) The medical record for R75 revealed three transfers dated 1/24/25, 2/19/25, and 2/24/25. The medical record did not indicate a written notification of transfer or a bed hold policy was given to R75 or their responsible party. Review of policy titled, Bed Hold and Return Guideline, dated 4/25/19, read in part, Purpose: It is the practice of that residents who were transferred to the hospital or go on a therapeutic leave are provided with written information about the State's bed hold duration and payment amount before the transfer .Residents and their representatives will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave . Review of policy titled, Transfer and Discharge Guidelines, dated 11/28/17, read in part, Purpose: This guidance supports safe discharges and transfers for all residents, regardless of initiating party. Guideline: The facility will provide proper and timely notice to a resident who will be discharged as required by regulations and laws .Notifications: The interdisciplinary team designee will meet with the resident and resident representative as applicable to review the discharge/transfer notice and its contents .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 resident .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview, and record review, the facility failed to revise and update care plans to reflect resident status for one Resident (#54) of 18 Residents reviewed for care plans. Findings include: Resident #54 (R54) R54 was admitted on [DATE] with diagnoses including stroke, quadriplegia, dysphagia (difficulty swallowing) following a stroke, protein-calorie malnutrition and anemia. The Minimum Data Set (MDS) assessment dated [DATE] indicated R54 had a feeding tube in place on admission and while a resident. The MDS assessment dated [DATE] indicated a feeding tube was not in place. A physician order dated 4/21/25 read, Contact Digestive Health to notify them of removal of PEG tube (percutaneous endoscopic gastrostomy tube inserted directly into the stomach providing an alternative for individuals who cannot swallow or received adequate nutrition orally.) and if any other follow up is needed, Patient/guardian decline replacement at this time. A physician order for Regular diet, Pureed texture, Honey-Thick consistency was in place and noted as last revised 11/8/24. During an interview on 5/21/25 at 4:24 PM, Licensed Practical Nurse (LPN) O stated R54's feeding tube had been out (removed) several months ago. He was not getting any food or fluid through a PEG tube. The current care plan for R54 was reviewed and included a nutritional risk focus due to the history of stroke, and conditions of dysphagia, malnutrition and many other nutritional concerns including, need for pureed textures and thickened liquids since advanced from NPO (nothing by mouth) status. The goal section for this care plan focus included, The resident will tolerate tube feed regimen without s/s (signs/symptoms) intolerance. Date initiated: 3/18/2024 The target date to accomplish this goal was listed as 7/6/2025. The interventions for this focus and goal included, Maintain NPO (nothing by mouth) status unless cleared for oral intake by ST/SLP (Speech Therapist/Speech Language Pathologist) Date initiated: 3/18/2024. The facility policy titled Careplan (SIC) Standard Guidelines dated effective on 11/28/2017 read in part, . The interdisciplinary team will continue develop (SIC) a resident/client centered care plan that includes problem, need, or strength statements, measureable (SIC) goal statements and resident/client specific interventions . The care plan is to be revised to reflect the current status of the resident. The care plan will be reviewed through out the resident's stay upon admission, quarterly and with changes in condition .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49302 Based on observation, interview, and record review, the facility failed to provide scheduled showers for two sampled Residents (#18, #73) and three Confidential Residents (CR#6, #9, and #14) of 18 Residents reviewed for Activities of Daily Living (ADLs). Findings include: During the resident council meeting conducted on 5/1/25 at 11:00 AM, three Residents who wished to remain confidential stated that they do not receive showers on a consistent basis and expressed subsequent feelings of frustration. Confidential Resident (CR)-14 reported getting less than one shower per week and sometimes going up to two weeks without a shower. CR-14 indicated each resident was scheduled to receive two showers per week. CR-6 stated they received, Maybe one shower per week. CR-9 explained, If they're [facility] short of help, they always come in and say we can't do showers today. 45123 Resident #18 (R18) During an interview on 5/20/25 at 11:38 AM, R18 was observed in their room lying in bed. R18's hair was uncombed and appeared greasy. R18 was asked when the last time they received a shower and replied, I was supposed to get one last Sunday, but they (facility staff) told me they could not give me a shower because of short staffing. Once I went 18 days without a shower. The medical record for R18 revealed an admitted to the facility on [DATE] with a primary diagnosis of type 2 diabetes mellitus. R18 had a Brief Interview Mental Status (BIMS) assessment score of 9 out of 15 indicating moderately impaired cognition. The medical record for R18 also included the documentation for Bathing/Showering Monday PM and Thursday AM and PRN [as needed]. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair) from the last 90 days as follows: - 2/24/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 2/27/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 3/6/25 - No offer of a shower or shower received. (continued on next page)

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The Villa at the Bay	1500 Spring St Petoskey, MI 49770

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 3/13/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 3/20/25 - No offer of a shower or shower received. - 3/24/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 3/27/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 3/31/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 4/3/25 - No offer of a shower or shower received. - 4/7/25 - No offer of a shower or shower received. - 4/10/25 - No offer of a shower or shower received. - 4/14/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 4/17/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 4/21/25 - No offer of a shower or shower received. - 4/24/25 - No offer of a shower or shower received. - 4/28/25 - No offer of a shower or shower received. - 5/1/25 - No offer of a shower or shower received. - 5/5/25 - No offer of a shower or shower received. - 5/8/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 5/12/25 - Refused shower. - 5/15/25 - No offer of a shower or shower received. - 5/19/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. This data indicated that R18 had not received scheduled showers for 23 out of 25 shower opportunities. R18 did not receive a shower from 4/23/25 through 5/11/25 (19 days). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40383 Resident #73 (R73) On 5/20/25 at 11:38 AM, R73 was observed in the hallway shouting in a loud voice, I have been asking to take a shower for about 10 days. Registered Nurse (RN) E responded to R73, Your day is tomorrow but (the shower aid) can try to squeeze you in (today). You are on Wednesdays and Saturdays (referring to R73's schedule for showers). R73 responded, I have not had a shower on either one for a while. The medical record for R73 revealed an admitted to the facility of 4/11/25 with a primary diagnosis of osteomyelitis in the left ankle and foot, an inflammation of the bone caused by infection. R73 had a Minimum Data Set (MDS) assessment dated [DATE] which noted a BIMS assessment score of 15 out of 15 indicating intact cognition. During an interview on 5/20/25 at 12:09 PM, R73 was observed in his room placing cool wet washcloths on his shoulders and complaining about an uncontrollable itch he was experiencing across his entire upper torso. He stated if he could have a shower that may help his itching. R73 said he would do it himself if they let him as he had not had a shower in a long time. The medical record for R73 also included the documentation for Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair) from the last 30 days as follows: - 4/28/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 4/29/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. - 5/4/25 Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. This data indicated R73 had a shower on 4/28/25, 4/29/25, and 5/4/25. No showers were documented from 5/4/25 until the resident was requesting a shower on the morning of 5/20/25. During an interview on 5/22/25 at 1:14 PM, the Director of Nursing (DON) acknowledged scheduling of showers is done but the communication from the computer to the CNAs (Certified Nurse Aides) was missing. The DON confirmed R73 did miss his shower for at least 10 days as R73 had reported. The DON stated many showers had been missed. The facility policy titled Activities of Daily Living (ADLs) dated effective 5/7/2020 and without a revision date, read in part: .In accordance with the comprehensive assessment, together with respect for individual resident needs and choices our facility provides care and services for the following activities: Hygiene: Bathing dressing, grooming and oral care .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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** 34568 Intake: MI00150656 This citation has two separate deficiencies. Based on interview and record review, the facility failed to provide all necessary care and services for one resident (R128) of one resident reviewed for quality of life, resulting in R128 not maintaining his highest practicable well-being, being hospitalized three times and endangering his life. Findings include: Review of R128's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including multiple right rib fractures and alcohol dependence with withdrawal. R128 was his own responsible party for medical and financial decisions. Review of R128's Discharge Summary from [Hospital Name] dated 3/4/25 read, in part, .Patient is a pleasant 78 y.o. (year old) male who tripped over a tv cord the morning of admission (3/2/25) and had right sided chest wall pain. He was diagnosed with multiple right sided rib fractures, however refused hospital admission .He then went home and slipped and fell on the ice of his driveway and returned having never made it inside his house. This time he did strike his had [sic] and had questionable LOC (loss of consciousness). On second presentation to the ED (emergency department), he was only complaining of right sided chest wall pain. He was found to have fractures to R (right) ribs 7, 8, 9. He was admitted to the ICU (intensive care unit) given the severity of his rib fractures to monitor his vital signs and oxygenation .He demonstrated some signs of alcohol withdrawal, mainly tremors. This was treated satisfactorily with oral Librium (medication used to treat anxiety or alcohol withdrawal) .He is being discharged to [Facility Name] in stable condition .He will be sent on a 3-day taper of oral Librium to prevent DT's (delirium tremens) while at the facility .Medications: chlordiazepoxide (Librium) 75 mg (milligrams) to be given evening of 3/4/25, 50 mg BID (twice a day) to be given on 3/5/25, 25 mg BID to be given on 3/6/25 . Review of R128's Physician Note dated 3/5/25 read, in part, .Overall the patient remained stable although he did develop concerns of minor alcohol withdrawal in which he was discharged to [Facility Name] for subacute rehab with oral Librium taper. Upon arrival to [Facility Name] the patient was stable with mild tremor. Librium was not stocked in the back up medications and the patient did not come with any from the hospital therefore I did place him on Ativan 1 mg x (times) 1 with .5 mg Q4hrs as needed .He has mild tremor and anxiety . Assessment: Alcohol withdrawal syndrome without complication - with chronic alcohol abuse and acute alcohol withdrawals. Mild with tremor and agitation. Vitals stable. Continue Ativan taper as ordered with PRN Ativan x 7 days. Continue thiamine and folic acid as ordered. Monitor closely, vitals every shift x 3 days . Review of R128's Medication Administration Record (MAR) for March 2025 revealed two Physician Orders for Librium which read as follows, Librium 25 mg 1 capsule by mouth two times a day for ETOH for 1 day (3/5/25) and Librium 25 mg 2 capsule by mouth two times a day for ETOH for 1 day (3/4/25). During review it was confirmed that R128 did not receive either order of his Librium medication. Review of R128's Progress Notes read, in part, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	3/4/25 08:22 This writer received a phone call from primary nurse at 0020. Primary nurse stated that resident became extremely agitated for no apparent reason and was trying to rip the TV off of the wall. PRN Ativan was given. Resident is a heavy ETOH user, prior to hospitalization and admission and is suspected to be going through withdrawals. NP (Nurse Practitioner) was notified this morning. She would like resident to have Ativan this morning 1 mg if Librium did not come in. 3/5/25 12:04 Med with (R128) to get food preferences. (R128) was very out of it had trouble answering my questions . 3/5/25 17:53 Pt (patient) medicated throughout shift for agitation and pain . 3/7/25 08:11 .Sending out to hospital due to ETOH and elevated blood pressure, complaining of chest pain and stating that he is having a heart attack . 3/7/25 15:25 Resident stated that he feels like he is dying, and can't breath. Resident appears to have tremors, increased anxiety and agitation, denies auditory or visual hallucinations. PRN Ativan given . 3/7/25 16:38 Resident extremely agitated stated he was calling the police, there was people trying to take over his home, stated he would walk home in his pajamas if he had to. Appears to be having delusions and agitation related to alcohol withdrawal. NP contacted. Gave one time order for Ativan .5mg and lisinopril 20mg. Asked that vitals be rechecked in 1 hour and texted to her. Primary nurse notified. 3/7/25 20:56 This writer was notified that the resident was yelling at staff exit, having episodes of delirium. Upon assessment the residents blood pressure was elevated, immediate action was taken blood sugar obtained. Resident was oriented only to person, slurred speech, right sided facial drooping, ataxia NIH performed with positive results. NP notified with an order to send out . 3/7/25 22:17 Resident was walking on his own, very unsteadily, and he tried to go out the back door. He was pushing on the handle making the alarm go off. He also tried to set off the fire alarm .He was given .5mg Ativan, on 4 different occasions .he said Don't touch me, I'm going to get my gun .he called 911 and told the operator that he was being held against his will .he was going to kill everyone, one by one .police officers came . 3/7/25 23:13 .Per nurse patient is detoxing from alcohol, has been having high blood pressure despite several Ativan doses. He tried eloping several times, threatened to kill people. Nurse states that the new nurse that is coming on shift does not feel comfortable in taking care of this patient and thus is requesting the patient go back to the hospital . 3/8/25 14:21 Resident returned from [Hospital Name] . 3/8/25 18:08 Resident was observed to be having aggressive behaviors. Attempted to his glass door with oxygen tank. Threatening staff. Resident was extremely agitated and having delusional thoughts. He called 911 and told the police he was being held against his will . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R128's Physician Note dated 3/7/25 read, in part, .This patient is being seen today in follow up ER visit that occurred last night. The patient developed increased anxiety and hypertension and was sent to [Hospital Name] .the patient was given additional dose of linisonpril 20mg, oxycodone 5mg, and Librium 50mg and discharged back .Assessment: Alcohol withdrawal syndrome without complication .extended Ativan taper as ordered with continued PRN Ativan .Addendum: Staff requested repeat evaluation on the afternoon of 3/7/25 as the patient was requestioning to go to the ER. Upon exam, the patient notes he needs to go to the hospital because he is dying. He notes he is having anxiety and shortness of breath .Approx (approximately) 1 hour later the staff did call me again stating the patient called 911 himself stating he wanted the police to take him to the hospital .At 2000 the staff called and stated the patient was having acute right facial droop, hypertension, slurred speech, weakness with ataxia. At this point EMS was called and the patient was transferred to the hospital .Assessment: Alcohol withdrawal syndrome without complication . Review of R128's Physician Note dated 3/10/25 read, in part, The patient is being seen today in follow up from 2 ER visits over the weekend. The patient has been having acute alcohol withdrawal in which he developed agitation and delirium .the patient was treated for increased alcohol withdrawal and discharged back .upon arriving back records reveal the patient became agitated and was threatening to shoot staff with a gun and was aggressive therefore staff requested the patient go back to the ER. The patient was kept in the ER overnight in which he was noted to have persistent delirium and started on Risperidone .25mg twice daily and his symptoms did improve. The patient was brought back to [Facility Name] on 3/8/25 . Review of R128's ED summaries read, in part, Admit 3/7/25 01:16 He is brought to the ED by EMS (Emergency Medical System) from [Facility Name] .It is a bit unclear why the patient is here in the ED this evening .vital signs on arrival are significant for elevated blood pressure .We did call the [Facility Name]. Nursing staff spoke with their nurses .I did review his discharge summary from trauma surgery several days ago. It was noted that he was discharged with 3 days of Librium to finish his taper. Nursing staff at [Facility Name] did confirm that he has not been taking this, therefore maybe this is contributing to his elevated blood pressures .I have also ordered him a dose of Librium . Admit 3/8/25 00:04 Returns to the emergency department, his current skilled nursing facility where he was residing for rehabilitation purposes reports that they are unable to care for him, there is no clear report as to what exactly is occurring that is precluding them from caring for him, they alleged that it may be because of alcohol withdrawal .He has been seen in the emergency department 3 times in the past 24 hours . An interview was conducted with RN U on 5/22/25 at 11:39 a.m. RN U recalled R128 and said, It was kind of wild and crazy those few days, I remember him (R128) going through active detoxing. His behaviors were crazy. RN U confirmed he was not provided any additional resources or education for detoxing residents. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Former Director of Nursing (DON) V on 5/22/25 at 12:06 p.m. DON V stated that R128 was suffering from severe withdrawals and having delusions and behaviors. DON V confirmed R128 never received Librium as the facility could not fill that order from the hospital and instead was given Ativan. DON V confirmed R128's behaviors continued, and the facility felt they could no longer care for the resident no longer felt comfortable doing so and discharged him 3 separate times to the emergency department. DON V stated the staff were not provided any additional education for residents who are suffering from withdrawal symptoms. An interview was conducted with Certified Nurse Aide (CNA) Q on 5/22/25 at approximately 10:30 a.m. CNA Q recalled R128 and said, I remember him having a lot of behaviors, he was taking oxygen tanks and throwing them at the exit doors, he called police, he was very scary and threatening us. I heard that he was having alcohol withdrawal. CNA Q recalled not having proper training on how to properly care for residents who are having withdrawal symptoms. Review of R128's Care Plans read, in part, Date Initiated: 3/6/25 Recent history of substance abuse; Goal: Resident will be in safe environment during stay at facility; Interventions: Complete review using medical record and resident/family interview, Education to resident on potential injury related to ordered medications and interaction with substances abuse, Establish resident goals, Notify MD (Medical Director) if resident appears impaired (prior to administering medications), Social Services referral of emotional support, Use calm and empathetic approach for communication . An interview was conducted with Regional Clinical Registered Nurse (RN) L on 5/22/25 at 11:29 a.m. who confirmed the facility does not have an alcohol withdrawal or assessment. 45123 Based on observation, interview, and record review, the facility failed to provide standards of care for hypoglycemia and diabetes management for one Resident (#5) of 18 residents reviewed for quality of care. Findings include: Resident #5 (R5) The medical record for R5 revealed an admitted to the facility on [DATE] with a primary diagnosis of diabetes mellitus. R5 had a BIMS assessment score of 15 out of 15 indicating intact cognition. On 5/20/25 at 11:12 AM, an observation was made of R5 in their room sitting on the side of their bed without any pants on. R5 was asked how they were doing and if they had any recent falls and replied, Yes, I had low blood sugar and I bumped my leg on my walker (four-wheeled walker). R5 was observed with a bandage on their left leg. R5 stated that orange juice does not work well if their sugar is low, and milk works best for them. Review of R5's medication administration record (MAR), dated 5/2025, revealed an order for lispro solostar 100 unit/ml (milliliter) pen-injector. Inject as per sliding scale: if 0 - 199 = 0; 200 - 250 = 2; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	251 - 300 = 3; 301 - 350 = 4; 351 - 500 = 5; 501 - 999 = 6 Call physician if BS [blood sugar] if (sic) greater than 500. Review of fasting blood glucose sugar levels (FSBS), dated 4/27/25 through 5/19/25, revealed the following: - 4/27/2025 7:23 AM, 44.0 mg/dL (milligrams/deciliter) - no progress note. - 4/27/2025 7:38 AM, 64.0 mg/dL - no progress note. - 4/28/2025 8:06 AM, 38.0 mg/dL - no progress note - no follow-up FSBS. - 4/30/2025 7:24 AM, 56.0 mg/dL - no progress note - no follow-up FSBS. - 5/5/2025 11:34 AM, 47.0 mg/dL - no progress note. - 5/5/2025 11:47 AM, 54.0 mg/dL - no progress note - no follow-up FSBS. - 5/9/2025 11:57 AM, 69.0 mg/dL - no progress note - no follow-up FSBS. - 5/17/2025 12:22 AM, 42.0 mg/dL - no progress note - no follow-up FSBS. - 5/18/2025 11:58 AM, 55.0 mg/dL - no progress note - no follow-up FSBS. - 5/19/2025 11:47 AM, 58.0 mg/dL - no progress note. - 5/19/2025 11:59 AM, 58.0 mg/dL - no progress note - no follow-up FSBS. Review of R5's progress notes, dated 4/27/25 through 5/19/25, lacked any notification to the physician of a low blood glucose level and no follow-up on the intervention or status of R5. On 5/21/25 at 12:15 PM, an interview was conducted with the Director of Nursing (DON) regarding their expectation for nursing encountering a resident with blood glucose levels below 70 mg/dL. The DON replied, I would expect to see a progress note communication on the physician notification, the interventions, and the repeat FSBS until the blood sugar was within normal limits. Review of policy titled, Diabetes Management, dated 6/29/17, read in part, Purpose: To develop a practice in which our facility consistently provides care for the resident with diabetes. Guidelines .Nursing Evaluation / Symptoms: Blood glucose monitoring .Results <70 or >400 indicate hypo or hyperglycemia require immediate follow up. Determine with the physician / extender if the individual has specific parameters to monitor .Nursing intervention .Evaluate signs and symptoms of diabetes complications .Notify the physician of any findings .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to readily identify, promote healing, and prevent the development of pressure injuries for two Residents (#26 & R42) out of three residents reviewed for pressure ulcer care. This deficient practice resulted in R26 developing a stage 3 pressure ulcer that worsened into a stage 4 pressure ulcer, and R42 developing infection and the deterioration of pressure wounds. Findings include: Resident #42 (R42) The medical record for R42 revealed an admitted to the facility on [DATE] with a primary diagnosis of pneumonia. R42 had a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15 indicating intact cognition. On 5/20/25 at 12:04 PM, an observation was made of R42 in their room and lying in bed with a pillow under their left side and both heels touching the bed. R42 was asked when the last time staff had turned and repositioned them and replied, Since last night. R42 was asked if they had a pressure ulcer and replied, Yeah, on my buttocks. R42 did not have a personal protective equipment (PPE) cart outside of their room door and no used PPE was observed in the trash cans in their room. R42 was asked how often they normally get turned and repositioned and replied, Usually every three to four hours. R42 was noted not to be wearing puffy boots while in bed. Review of R42's Quarterly Minimum Data Set (MDS), dated [DATE], read in part, .Section E: Behaviors . Rejection of care: Behavior not exhibited .Section G: Functional abilities and goals .Substantial/maximum assistance for toileting, upper body dressing, personal hygiene, and rolling left to right .Section M: Skin conditions .Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device (checked) .Risk of pressure ulcer development check yes .Unhealed pressure ulcers checked yes .Number of stage 2 pressure ulcers - two. Number of these stage 2 pressure ulcers that were present upon admission/reentry - two . Number of stage 3 pressure ulcers - one. Number of these stage 3 pressure ulcers that were present upon admission/reentry - one . Number of stage unstageable pressure ulcers - three. Number of these stage unstageable pressure ulcers that were present upon admission/reentry - zero . Number of venous and arterial ulcers - two . Review of R42's Braden assessment for determination of developing pressure ulcer risk, dated 4/15/25 at 3:10 PM, revealed that R42 was at, very high risk. Review of R42's active wound summary list, dated 5/21/25, revealed the following: 1.) Wound site: buttocks/hip left, date identified 1/17/25, type: pressure, classification: ulceration, clinical stage: unstageable, and measured 0.70 length (L) cm (centimeters) x 0.50 width (W) cm x 0.00 depth (D) cm, 2.) Wound site: left flank lower wound, date identified 12/16/24, type: pressure, classification: ulceration, clinical stage: unstageable, and measured 2.40 L cm x 3.00 W cm x 0.10 D cm, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3.) Wound site: left flank upper wound, date identified 3/25/25, type: pressure, classification: ulceration, clinical stage: stage 3, and measured 2.70 L cm x 4.20 W cm x 0.20 D cm, 4.) Wound site: left buttocks 2 medial, date identified 1/17/25, type: pressure, classification: ulceration, clinical stage: unstageable, and measured 2.00 L cm x 1.30 W cm x 0.30 D cm, 5.) Wound site: left heel, date identified 5/20/25, type: pressure, classification: ulceration, clinical stage: unstageable, and measured 3.50 L cm x 4.60 W cm x 0.00 D cm, 6.) Wound site: right buttock, date identified 2/27/25, type: pressure, classification: erythema, clinical stage: healed stage 2, and measured 2.00 L cm x 1.50 W cm x 0.00 D cm, 7.) Wound site: sacrum, date identified 9/13/24, type: pressure, classification: ulceration, clinical stage: stage 3, and measured 8.00 L cm x 2.50 W cm x 0.70 D cm. Review of R42's task for behavioral monitoring for refusals of care, dated 4/21/25 through 5/20/25, revealed no refusals of care and no behaviors observed. Review of R42's care plan, dated 5/2/25, read in part, .Focus: The resident is on antibiotic therapy r/t (related to) cellulitis to buttocks. Goal: The resident will be free of any discomfort or adverse side effects of antibiotic therapy .Interventions: Administer antibiotic medications as ordered by physician .Focus: The resident has pressure ulcer (to) coccyx, sacrum, buttocks, (and) left scapula region. Goal: The resident's skin risk for further alteration in skin integrity will be minimized by staff allocated interventions. Interventions . Assess/record/monitor wound healing (q week) [every week] Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing process .The resident needs to turn/reposition at least every 2 hours, more often as needed or requested .Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate . On 5/22/25 at 11:55, an observation was made of R42's wound dressing changes in their room with the Director of Nursing (DON), the Regional Clinical Registered Nurse (RN) L, and Licensed Practical Nurse (LPN) K to measure, assess, and complete wound dressing changes on R42's buttocks area. Findings include: 1.) Pressure ulcer, stage 3 to left buttocks (next to intergluteal cleft), facility acquired and measured 8.00L cm x 3.00W cm x 0.20D cm, 2.) Pressure ulcer, stage 3 to left buttocks (lateral side), facility acquired and measured 0.75L cm x 1.00W cm x 0.10D cm, 3.) Pressure ulcer, stage 3 to left lower buttocks facility acquired and measured 2.00L cm x 1.00W cm x 0. 50D cm with tunneling, 4.) Pressure ulcer, unstageable to left heel, facility acquired and measured 3.50L cm x 4.60W cm x 0.00D cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/22/25 at 12:30 PM an interview was conducted with the DON who was asked if the documentation for the wound summary should reflect the actual presentation of the wound weekly after being assessed and replied, Yes, I don't know why it doesn't. We need to do a better job with documentation of wound assessments and measurements. (R42's) Pressure ulcers should not have developed or worsened. 49302 Resident #26 (R26) Review of R26's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including dementia and aphasia (difficulty expressing thoughts). Review of Section C (Cognitive Patterns) of R26's most recent Minimum Data Set (MDS) Assessment, dated 3/21/25, revealed R26's cognitive skills for daily decision making were, severely impaired. On 5/20/25 at 1:35 PM, a phone interview was conducted with R26's son and Durable Power of Attorney (DPOA) R regarding his overall satisfaction with care received at the facility. DPOA R stated deterioration of a wound on R26's right buttock contributed to her overall decline and eventual enrollment with hospice services. Review of progress note dated 2/28/25 written by Nurse Practitioner (NP) S read, in part: Chief complaint/Nature of Presenting Problem: Progressing pressure ulcer, hospice discussion . History of Present Illness: [R26] is being seen today due to [a] progressing pressure ulcer. The staff notes [R26's] pressure ulcer is a stage 4 [extending through all layers of skin, exposing muscle, tendons, or bones], and [R26] overall continues to decline over time . hospice was recommended . Review of a R26's Wound Summary documentation read, in part: Site: right ischial tuberosity . Type: Pressure . Source: Facility Acquired . Date identified: 1/6/25 . Clinical stage: stage 3 . Review of R26's skin assessments revealed the most recent documented assessment prior to identification of the stage 3 pressure wound on 1/6/25 occurred on 12/18/25, an 18 day lapse between routine skin assessments. Review of R26's most recent Braden Scale for Predicting Pressure Sore Risk, dated 7/1/24, revealed a score of 12, indicating high risk of pressure ulcer formation. Review of R26's EMR revealed the following progress note written on 2/14/25 at 11:04 AM: .wound to ischial tuberosity has worsened in condition and is now a stage 4 . On 5/22/25 at 1:33 PM, a group interview was conducted with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Regional Clinical Registered Nurse (RCRN) L regarding wound prevention and care expectations. The DON stated skin assessments should be completed on a weekly basis and documented in the EMR system. All parties agreed identification of the pressure ulcer on R26's right ischial tuberosity should have occurred prior to development into a stage 3 wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R26's plan of care revealed a focus initiated which read: [R26] has actual and potential for impairment to skin integrity r/t [related to] limited mobility, incontinence, dementia, hydrocephalus, venous insufficiency. An intervention, initiated on 6/11/24, read: Weekly skin assessment. Review of the facility policy titled, Skin Alteration Documentation, revised 2/11/19, read, in part: .patients without skin issues will have skin observed daily during cares and observations weekly by licensed nurses .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview, and record review, the facility failed to ensure restorative nursing services were provided to increase range of motion and/or to prevent further decrease in range of motion (ROM) for one Resident (#54) of one resident reviewed for limited range of motion. Findings include: Resident #54 (R54) R54 was admitted on [DATE] with diagnoses including stroke, quadriplegia, cerebral palsy, and traumatic brain injury. The Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15, signifying R54 was cognitively intact. On 5/20/25 at 11:51 AM, R54 was observed in his bed with severely contracted hands. R54 was able to open his fists slightly and said no staff helped him work on his hands and it, Probably would be a good idea. The physician order dated 2/9/25 included, Splint to L (left) hand off while awake and on at night every day and evening shift for hand splints. R54 stated he did not always like to wear the splint but sometimes he wears it. During an interview on 05/22/25 at 9:48 AM, Certified Occupational Therapy Assistant (COTA) Q discussed the restorative therapy program following a physical therapy (PT) or occupational therapy (OT) regimen. COTA Q said, We fill out a referral to nursing, if we think the resident would be good (benefit from a) restorative (program). They (the nursing department) take it from there. COTA Q reviewed the therapy notes for R54 and reported, We finished up with (R54) in February. The date of his last therapy OT and PT was 2/17/25 . hand splints were recommended, and a ROM program was recommended. The medical record OT Discharge Summary dated 2/27/25 included, Discharge Recommendations: OOB (out of bed) for meals. ROM Restorative program . During an interview on 5/22/25 at 9:17 AM, the Director of Nursing (DON) stated the facility did not have a restorative program and did not have a restorative nurse or a restorative Certified Nurse Aide (CNA). The DON said, It is something we would like to establish. The facility policy titled, Restorative Nursing Services dated as revised on 7/2017 and presented on 5/21/25 at 1:00 PM read in part, Residents will receive restorative nursing care as needed to help promote optimal safety and independence . Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview, and record review, the facility failed to provide proper infection control measures pertaining to indwelling catheters (a tube inserted into the bladder to accommodate emptying of the bladder) for one Resident (#8) of two residents reviewed for indwelling catheters. This deficient practice resulted in the potential for infections and illness. Findings include: Resident #8 (R8) Review of R8's electronic medical record (EMR) revealed an admitted [DATE] with diagnoses including neuromuscular dysfunction of bladder. R8's 4/5/25 Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 14/15 indicating no cognitive impairment. R8 was also marked on the MDS for the use of an indwelling catheter. On 5/21/25 at 2:07 p.m., R8 was observed being assisted by staff to go outside to the smoking shed which is across the facility parking lot. R8 was being pushed by an unidentified staff member in her wheelchair. R8's indwelling catheter urinary collection bag was observed underneath the wheelchair seat, not in a privacy bag, and dragging on the pavement ground with auditory sound of the bag hitting the pavement. The drainage tube tip was also noted to be hitting the pavement as R8 was being assisted. On 5/22/25 at 1:40 p.m., R8 was observed asleep in her wheelchair, in the dining room. The indwelling catheter urinary collection bag was observed uncovered and on the floor with the drainage tube tip touching the ground. On 5/22/25 at 3:00 p.m. an interview was conducted with the Director of Nursing (DON). The DON confirmed indwelling urinary catheter bags should remain off the floor and in a privacy bag. Review of the facility's Catheter Care (Indwelling Catheter) policy did not identify that urinary catheter bags should remain off the floor.

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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** 49302 Based on observation, interview, and record review, the facility failed to ensure sanitary storage, labeling, and cleaning of respiratory equipment for three Residents (#23, #42, and #61) of 3 residents reviewed for respiratory services. Findings include: Resident #23 (R23) Review of R23's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with hypoxia (low levels of oxygen in body tissues). Review of R23's admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 6, indicative of severe cognitive impairment. Review of R23's EMR revealed the following physician's order, initiated 5/8/25: Continuous O2 [oxygen] via (NC/MASK) [nasal cannula] at 2 L/m [2 Liters per minute]. On 5/20/25 at 10:52 AM, an unoccupied wheelchair was observed at the foot of R23's bed with undated oxygen tubing connected to a portable oxygen tank. The tubing was observed laying in the wheelchair seat with no protective covering. R23 was observed sleeping in bed, wearing an undated nasal cannula attached to a concentrator. On 5/21/25 at 12:45 PM, an unoccupied wheelchair was again observed at the foot of R23's bed with oxygen tubing connected to a portable oxygen tank. The tubing was observed laying in the wheelchair seat with no protective covering. Additional undated oxygen tubing was observed attached to a concentrator and resting on the floor. On 5/22/25 at 8:46 AM, undated oxygen tubing was observed attached to a concentrator resting on the floor in R23's room. The nasal cannula prongs were observed in direct contact with an unkempt soaker pad located on the bed. On 5/22/25 at 8:49 AM, an interview was conducted with Registered Nurse (RN) B regarding respiratory equipment storage and labeling expectations. RN B stated some residents have an order in their Treatment Administration Record (TAR) to ensure oxygen tubing gets changed on a weekly basis. RN B stated the expectation is for all oxygen tube to be dated, changed weekly, and stored in a bag when not in use. Review of R23's EMR revealed no order for weekly oxygen tubing changes. 45123 Resident #42 (R42) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record for R42 revealed an admitted to the facility on [DATE] with a primary diagnosis of pneumonia. R42 had a BIMS assessment score of 15 out of 15 indicating intact cognition. During an interview on 5/20/25 at 12:04 PM, R42 was observed in their room lying in bed. R42's undated nebulizer was observed lying on top of their bedside table in one piece with visible condensation in the medication cup. R42 was asked when the last time the nebulizer was rinsed out by staff and replied, It has been like that since last night. The medical record for R42 revealed a physician order which read, Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) mg/ml (milligram per milliliter), 1 vial inhale orally four times daily. On 5/22/25 at 12:15 PM, R42's undated nebulizer was again observed lying on top their bedside table in one piece with visible condensation in the medication cup. Resident #61 (R61) The medical record for R61 revealed an admitted to the facility on [DATE] with a primary diagnosis of dementia. R61 had a BIMS assessment score of 8 out of 15 indicating moderately impaired cognition. During an interview on 5/20/25 at 11:27 AM, R61 was observed lying in their bed. R61 had an oxygen concentrator next to their bed with a nasal cannula attached to the concentrator dated 3/24/25. R61 was receiving oxygen at 2 liters via nasal cannula. R61 was asked about the oxygen equipment being maintained by the facility staff and was unable to answer if the oxygen tubing was changed regularly. R61 stated that they had the flu about a month ago. R61 also had a nebulizer hanging off the back of the oxygen concentrator that was dated 3/24/25. On 5/20/25 at 12:14 PM, an interview was conducted with Certified Nurse Aide (CNA) I who was asked what the date read on R61's oxygen tubing. CNA I stated the nurses are responsible for changing the tubing and confirmed the date was 3/24/25. CNA I replied, That date does not seem right. On 5/20/25 at 12:16 PM, an interview was conducted with CNA H who was asked about R61's oxygen tubing and replied, I am not really sure, that is a nursing thing. On 5/20/25 at 12:20 PM, an interview was conducted with Licensed Practical Nurse (LPN) D who was asked how frequently oxygen tubing and nebulizers were changed. LPN D replied, It is changed every week. Normally there is an order on the treatment administration record for the tubing and nebulizer to be changed every week on Sunday. Review of R61's treatment administration record (TAR), dated 3/1/25 through 5/20/25, revealed no order for R61's oxygen tubing or nebulizer to be changed weekly. On 5/22/25 at approximately 11:30 AM, a request was made to the Nursing Home Administrator (NHA) for a respiratory care policy. The NHA stated that the facility did not have a respiratory care policy.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49302 Based on observation, interview, and record review, the facility failed to ensure meals were served in accordance with the posted menu. Findings include: A confidential resident council meeting was conducted on 5/21/25 at 11:00 AM. When discussing meal choices at the facility, 8 of 14 confidential participants stated the facility frequently did not follow the posted meal plans. Confidential Resident (CR) #9 stated: They [facility] never give us a decent menu and never follow the menu they give us . It's an everyday occurrence. When asked if the inconsistencies happen at a particular meal, CR-9 replied, It's a surprise. 40383 On 5/20/25 at 12:25 PM, Resident #7 (R7) and Resident #16 (R16) stated they were not satisfied with the meals served at the facility. R7 stated the kitchen did not serve what was on the menu. On 5/21/25 at 8:29 AM, the meal assembly tray line was observed in the kitchen. Dietary Manager (DM) N stated the menu cycle being served was not correct as another manager had been in charge. The menu was titled Week 2 and was dated 5/11/25 through 5/17/25. The menu items were served for the Week 2 plan despite being on the Week 3 menu cycle. On 5/22/25 at 12:56 PM, R7 received her lunch and pointed to her meal and stated, See this is not on the menu. They messed up again. They never serve what is on the menu. Every meal is wrong. R7 said she and her roommate were looking forward to roast beef the day before according to the menu and instead We got noodles with tomatoes. R7 presented a copy of the menu which had been passed out to all residents. The menu was dated for 5/18/25 through 5/24/25 and was labeled Week 3. Therefore, the menu the kitchen was using was Week 2 and dated for the previous week, and the residents had the Week 3 menu and did not get the expected meal. On 5/22/25 at approximately 2:00 PM, DM N agreed he had not given the residents the correct menus nor had he changed the date on the posted menu. He had recognized the error in the menu distribution and had posted the menu which was being served in both dining rooms. When the posted menus were reviewed the dates had not been corrected and no menu items were listed for the lunch meal on 5/22/25, and that lunch menu had been blacked out. During a group interview on 5/22/25 at approximately 2:00 PM, the Nursing Home Administrator, and the Director of Nursing acknowledged the residents had said the menus have not been followed. Review of the facility policy titled, Food & Nutrition Services Food Preparation, undated, read, in part: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.cycle menus are planned by a dietitian at least two weeks in advance . the menu spreadsheet for the week is dated and available in the kitchen. The general menu is posted at visible places throughout the healthcare community . The menu of the day will be posted on each unit in a designated place where it will be readily available to clients, staff, and visitors .

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 34568 Based on observation, interview, and record review, the facility failed to consistently provide meals in a timely manner and/or consistently provide a nourishing snack to all 82 residents. This deficient practice resulted in the potential for residents to not have a hot meal or to have more than 16 hours between a substantial evening meal and breakfast the following day, decreased oral intake, and the potential for weight loss. Findings include: On 5/20/25 at 12:46 p.m., an interview was conducted with Resident #27 (R27) who was sitting in the dining room waiting for the lunch meal service to be delivered. R27 expressed frustration with having to wait such a long time for their meal. It's late and it's always been late. It was bad on the weekend this time too. It's constantly being served to us late, yesterday it was 1:45 p.m. before we got out meal, and it wasn't very good either. Around 1:00 p.m. R27 was observed going back to her room and stated she refuses to eat a meal that is this late. R27 was noted to not eat a lunch on 5/20/25. On 5/21/25 at 9:17 a.m., an interview was conducted with Resident #3 (R3) who was laying in her bedroom. R3 stated the meals had been delayed for quite a few days and expressed frustration in having to wait for meals to be delivered. It has been awful, by the time I get my breakfast, it will be time for lunch. 40383 During the lunch meal observation on 5/20/25 at 1:16 PM, the second food cart carrying the meals arrived to the 100 (North) hall. At 1:23 PM on the same day, the last tray on the 100 (North) hall food cart was taken out of the cart and delivered. During the lunch meal observation on 5/21/25 at 12:55 PM, the first food cart arrived to the 100 (North) hall. The second food cart arrived to the 100 (North) hall at 1:07 PM. The third food cart arrived to the 100 (North) hall at 1:15 PM, and the last tray on the third cart was taken out of the cart and delivered at 1:17 PM. The posted mealtimes were presented on 5/21/25 at 2:31 PM as follows: Breakfast served: South wing (300 hall) - 8 AM - 8:20 AM North wing (100 hall) - 8:30- 8:40 AM Center wing (200 hall) - 8:45-9 AM Lunch served: (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	South wing (300 hall) - 12 PM - 12:20 PM North wing (100 hall) - 12:30- 12:40 PM Center wing (200 hall) - 12:45-1 PM Dinner served: South wing (300 hall) - 5 PM - 5:20 PM North wing (100 hall) - 5:30- 5:40 PM Center wing (200 hall) - 5:45-6 PM During an interview on 5/21/25 at 12:45 PM, Resident #7 (R7) who resides on the North Hall stated she was dissatisfied with the meal arrival times. R7 said, We are getting breakfast after 9:00 (AM) and most of us are up at 6 or 6:30 (AM) and we have to wait . Lunch and dinner you never know (when the meals will arrive.) R16, who resides on the North Hall agreed saying mealtimes were sporadic and not served on a schedule. R16 stated, It would be nice if the meals were on time. During an interview on 5/21/25 at 12:49 PM, R22, a resident of the North Hall, said meals are sometimes late with breakfast arriving around 9:30 AM or whenever they bring it to us. R22 said dinner usually gets delivered at 6:30 at night. When asked if R22 received an evening snack, she replied, No, we have to ask (for a snack), and (we) do not always get one. During an interview on 5/21/25 at 1:20 PM, Dietary Manager (DM) N acknowledged the lunch trays that day were late. DM N was not familiar with the regulations on meal service hours and was unaware there must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, then up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. DM N had not met with the residents and did not know of anyone who had met with the residents to determine if the residents would agree on a 16-hour meal span. 49302 A confidential resident (CR) council meeting was conducted on 5/21/25 at 11:00 AM. When discussing evening snacks, 6 of 14 confidential participants stated they were frequently not offered a snack during the evening hours. CR-2 stated, We have to ask them [the facility] for snacks . sometimes they come back and sometimes they don't. A lot of times they don't show back up. Review of snacks offered in a 30-day look-back period revealed CR-2 was not offered an evening snack on 13 different occasions. CR-8 stated, We haven't been getting breakfast until well after 9:00 AM . We're getting really hungry by the time breakfast is coming around. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of snacks offered in a 30-day look-back period revealed CR-8 was not offered an evening snack on 7 different occasions. Review of Resident Council minutes dated 1/27/25 revealed the following question: How would you rate the quality of snacks provided between meals? The resident council selected poor as a response. Review of Resident Council minutes dated 3/3/25 revealed the following note: Snacks and water passes needed more at night. 7 of 14 confidential participants also voiced dissatisfaction regarding the timeliness of meals. CR-9 indicated residents frequently wait 30 minutes after the posted mealtimes for delivery of food trays. On 5/21/25 at 8:38 AM, breakfast meal service was observed on the secured dementia unit. On 5/21/25 at 8:40 AM, Certified Nursing Assistant (CNA) T was observed placing a breakfast tray in front of Resident #29 (R29) and continued to deliver trays to other residents. At 9:02 AM, CNA T was observed sitting next to the resident to assist with feeding, 22 minutes after initial placement of the tray. Review of Section GG in R29's Minimum Data Set (MDS) Assessment, dated 3/23/25, revealed R29 required total dependence for eating. Review of the posted meals time revealed service time for breakfast on the dementia unit (south wing) was 8:00 - 8:20 AM. On 5/21/25 at 12:20 PM, the lunch service was observed on the secured dementia unit. R29 was observed seated at a central table in a wheelchair. On 5/21/25, the mobile lunch carts arrived on the secured unit at the following times: At 12:24 PM, the first lunch cart arrived on the secured unit. At 12:32 PM, the second lunch cart arrived on the secured unit. At 12:36 PM, the third lunch cart arrived on the secured unit. On 5/21/25 at 12:43 PM, CNA T was observed placing a lunch tray in front of R29. At 12:52 PM, R29 was observed receiving dining assistance, 9 minutes after the tray was placed in front of her and 32 minutes after initial arrival in the dining room. Review of the posted meals time revealed service time for lunch on the dementia unit (south wing) was 12:00 - 12:20 PM. Review of Resident Council minutes dated 12/16/25 revealed the following prompt: (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Rate the following questions on a scale of 1-5 (1 being poor & 5 being excellent) .How has tray passing been? 2 out of 5. Review of Resident Council minutes dated 1/27/25 revealed the following question: Are you happy with the times that meals start and complete? The resident council selected poor as a response. Review of the facility policy titled, Meal Frequency and Preferences, issued 9/1/21, read, in part: Meal service schedules establish mealtimes that are appropriate for residents and optimize staff's ability to assist resident during meals. Residents are served in an efficient manner that emphasizes customer service . meal schedules are posted in resident care areas and dining rooms . residents needing assistance will be served last. When the tray is delivered the server will prepare the tray, sit by the bedside and assist the resident as needed . Review of the facility policy titled, Meal HS [at night] Snacks issued 9/1/21, read, in part: .Bedtime (a.k.a. HS) snacks will be provided for all residents . Nursing Services is responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety by: - storage of expired foods, - food preparation equipment not cleaned properly after use, - utensils and pans not properly cleaned and stored, - sanitizing solution not properly prepared, and - unit nourishment room had storage of outdated beverages and resident foods. This deficient practice has the potential to result in food borne illness among any and all 82 residents. Findings include: On [DATE] at 9:49 AM, the kitchen was toured with Dietary Manager (DM) N. The following observations were made: - Vanilla yogurt was in the walk-in refrigerator dated [DATE] - [DATE]. DM N stated the activity department dated this container and the first date would be the date the yogurt was opened, and the second date would be the date it should be used by. DM N said he would dispose of the yogurt as it was about a month past the use by date. - A gallon jar of picante sauce was in the reach-in refrigerator marked as opened ,d+[DATE] and expired on , d+[DATE]. - A nearly empty gallon jug of vanilla and a nearly empty gallon jug of molasses were stored under the prep counter and both had dark black drip trails of product on the outside of the containers and both lids were covered in brown product residue. DM N said of the vanilla container, That looks disgusting and referred to the jug of molasses as definitely unacceptable. - The hand crank can opener blade was covered with a brown sticky goo-like substance. When questioned, DM N said the substance on the blade was probably dirt and paper from opening cans. DM N said, It (the can opener) should go back every night (to the dishwasher). It did not get cleaned. - Quarter steamtable pans were observed to be stacked wet. DM N observed the moisture when the pans were separated and stated, It can create bacteria doing that (when pans are not air dried.) - The utensil bins were observed with seven serving scoops, measuring cups, and other service utensils with visualized bits of dried particles of food adhering to them. The bin itself was observed with loose crumbs and dried debris on the bottom of the bin which contacted the utensils stored in the bin. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A small pan of knives was observed on the clean rack. The knives were found lying in bits of paper and food debris. Several pieces of equipment were observed not clean. - The microwave had spattered brown hardened remnants of what appeared to be food on the door, walls and ceiling of the interior. - The mixer was covered indicating it was ready for use. After the mixer was uncovered, it was observed with a large white dried on glob of what appeared to be a batter on the undercarriage. The whisk beater attachment also contained white dried on residue . DM N suggested the dried-on glob was cake batter from production the previous evening indicating it had not been cleaned thoroughly after use. - The large meat slicer was also covered indicating it was ready for use. The slicer was uncovered and discovered to have bits of dried meat on the blade which had not been adequately cleaned after use. The three-compartment sink was filled and ready for use. The sink labeled for sanitizing was tested and registered as having no sanitizer. DM N was unsure if the employees had filled the sink with the proper hose or if the sanitizing system was not functioning correctly. The North nourishment refrigerator was observed with the following: - A container of a type of salad marked with the first name of a resident, but no label and no date the item was prepared or should be used by. - A 14-ounce container of sour cream marked with the first name of a resident, but no opened date or use by date. - A small 4-ounce container of pudding was not covered. This container was dated [DATE]. - A gallon pitcher of orange juice without a label, and without a prepared date or use by date. - There were three opened Med Pass supplement containers without an opened date or use by date. During the tour of the North Nourishment room on [DATE] at approximately 10:30 AM, Registered Nurse (RN) E stated the items (stored in the refrigerator) all should be dated. The related portions of the FDA Food Code 2017 are as follows: - ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO_EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. - ,d+[DATE].13 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. - ,d+[DATE].11 Hot Water and Chemical. After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: (A) Hot water manual operations by immersion for at least 30 seconds and as specified under S ,d+[DATE].111; (B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under SS ,d+[DATE].15, ,d+[DATE].112, and ,d+[DATE].113 and achieving a UTENSIL surface temperature of 71oC (160oF) as measured by an irreversible registering temperature indicator; P or (C) Chemical manual or mechanical operations, including the application of SANITIZING chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified under S ,d+[DATE].114. Contact times shall be consistent with those on EPA-registered label use instructions - ,d+[DATE].12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.

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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. 45123 Based on observation, interview, and record review, the facility failed to properly perform hand washing and hand hygiene during wound dressing changes. Findings include: Resident # 42 (R42) On 5/20/25 at 2:25 PM, an observation was made of R42 lying in their bed. R42 summoned Certified Nurse Aide (CNA) H to take a used fast food chain coffee cup R42 was using as a urinal from them prior to dressing change. The used fast food chain coffee cup had visible coffee stains on the outer edges of the cup. CNA H took the used fast food chain coffee cup from R42 and placed it on their bedside table. During wound care dressing changes for R42 on 5/20/25 at 2:25 PM, the following observations were made: - At 2:34 PM, Licensed Practical Nurse (LPN) D removed gloves and changed gloves without hand sanitization. - At 2:40 PM, LPN D removed gloves and washed their hands for only eight seconds, did not turn water on prior to dispensing soap, and turned water off with their bare hands. - At 2:45 PM, LPN D removed gloves and changed gloves without hand sanitization, then applied Dakin's solution to the wound. - At 2:48 PM, LPN D removed gloves without hand sanitization then applied cream to wound area. - At 2:53 PM, LPN D removed gloves and proceeded to washed hands by first applying soap on their hands then turning the water on and off with bare hands. - At 2:55 PM, LPN D removed the dressing from R42's right lower leg, did not change gloves and proceeded to wash the right lower leg. - At 2:56 PM, CNA H washed R42's left lower leg and assisted with a new dressing without re-applying new gloves after changing soiled linens. - At 3:03 PM, LPN D changed gloves and failed to use hand sanitization prior to putting on a new set of gloves. - At 3:05 PM, LPN D inspected R42's left heel and removed gloves to get the wound care nurse by exiting the room in their personal protective equipment (PPE). LPN D changed their mind and re-entered the room and put on new gloves without sanitizing their hands. - At 3:10 PM, LPN D washed their hands after performing dressing changes by first applying soap on their hands then turning the water on. LPN D washed their hands for only seven seconds and turned water off with their bare hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Handwashing / Hand Hygiene, dated 05/2022, read in part, Policy: Proper handwashing and hygiene will be performed by staff, practitioners, visitors and residents to help prevent the spread of infections .General Guidelines . 8. The use of gloves does not replace handwashing or hand hygiene. Handwashing: 1. All personnel must wash their hands for at least fifteen (15) seconds using antimicrobial or nonantimicrobial soap and water under the following conditions . r. After handling soiled or used linens, dressings, bedpans, catheters and urinals . u. After removing gloves or aprons .Alcohol-Based Hand Rubs: 1. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60 to 95% ethanol or isopropanol for any of the following situations . b. Before donning sterile gloves (the use of gloves does not replace handwashing/hand hygiene) .f. Before moving from a contaminated body site to a clean body site during resident care . j. After removing gloves .Procedure: Handwashing 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least fifteen (15) seconds under a moderate stream of running water, at a comfortable temperature. Hot water is unnecessarily rough on hands . 3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel .

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F 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough power supply for lighting all entrances and exits; equipment for fire detection and alarm systems, and extinguishers. 34568 Based on interview and record review, the facility failed to maintain an operable emergency electrical power system to ensure electrical power to life support systems in the event of a power outage, affecting all 82 residents in the facility. Findings include: Review of the facility's incident report, read, in part, An ice storm hit the region Saturday evening 3/28 . [Facility Name] lost power temporarily the evening of 3/28 and went to generator power. Power restored within a few hours but eventually went back down the morning of 3/29 and the building returned to generator use. The generator stopped working around 7 p.m. on 3/30, and the building lost power completely .The MAR/TAR (Medication Administration Record/Treatment Administration Record) was attempted to be printed out utilizing the backup computer, but the battery was not able to run both the laptop and printer at the same time . The generator was repaired and power restored via generator at 1 p.m. on 4/1/25 .grid power was finally restored at 5:40 a.m. on 4/2/25 . One resident who required 10 L (10 liters) of oxygen was sent to the hospital for the duration of the outage. The facility was afraid they would not be able to properly care for this resident without power. An interview was conducted with the Nursing Home Administrator (NHA), Director of Nursing (DON) and Regional Clinical Registered Nurse L on 5/22/25 at 3:10 p.m. The three staff members confirmed that the facility failed to follow their emergency procedures guide in obtaining a back up generator in the event the facility's current generator is out of operation. The three staff members confirmed that during the frequent times that the generator would cease to function properly, residents requiring oxygen were switched to portable oxygen tanks, residents who are on specialized air mattresses were converted to standard mattresses, and eventually they were able to reach the emergency kits which were behind locked doors and inaccessible at the beginning of the power outage to pass out some flashlights to staff while others used their personal phones as flashlights. The NHA also stated that they were unable to access residents' electronic medical records (EMRs) during this time as the computer back up battery was not functioning. Review of the facility's Electrical Power Outage Policy & Procedure read, in part, .The facility has an emergency backup generator that runs electrical power to the entire facility. Aside from the power transfer time from utility to emergency power, the facility will not experience any disruptions of operations .If the back-up generator fails during the outage, reference the Emergency Generator Power System Failure policy found within the policy section of the Disaster & Emergency Preparedness binder. Review of the facility's emergency Generator Power System Failure policy read, in part, .If a generator/Emergency Power Supply System should fail during a test, or during actual operations, or at other times, it will be repaired as quickly as possible. (If it cannot be returned to service and pass the monthly test within a few hours, a backup generator will be brought in and connected for use until the primary generator can be repaired and pass the test). (continued on next page)

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F 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Severe Weather: Blizzard-Snow-Ice Storm Policy and Procedure read, in part, .Make sure emergency power supply is operable . Review of the facility's Cold Weather Emergency-Loss of Heat or Extreme Cold Policy and Procedure read, in part, .In the event that there is decreased heat in the building and especially in the residents rooms because of a power outage, the maintenance department will implement the use of the emergency generator so that we will be able to provide heat by use of the emergency generator. The emergency generator will provide electricity to the entire facility .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 40383 Based on interview and record review, the facility failed to utilize their emergency plan to allow residents to directly communicate and alert staff members of their needs during a power outage and generator failure affecting all residents residing at the facility. This deficient practice resulted in resident helplessness and potential decreased emergent response times. Findings include: During an interview on 5/22/25 at 12:56 PM, Resident #7 (R7) stated, Oh yes, we remember the ice storm. They (the facility) had just so many flashlights and we were left in the dark. They did not have enough flashlights. It was coal black. The electricity went out and then the generator went out. There were no bells or whistles to call for the staff. We were on our own. It was bad. During an interview on 5/22/25 at 1:01 PM, R5 stated during the ice storm there were no flashlights, no bells, no whistles. We were out of luck. During an interview on 5/22/25 at 1:04 PM, Registered Nurse (RN) E recalled the ice storm and said We thought that flashlights for all would be a good idea, but there was not enough for everyone we found out. The call system was out. 34568 An interview was conducted with the Nursing Home Administrator (NHA), Director of Nursing (DON) and Regional Clinical Registered Nurse L on 5/22/25 at 3:10 p.m. The three staff members confirmed that the facility failed to follow their emergency procedures guide in obtaining a back up generator in the event the facility's current generator is out of operation. The three staff members confirmed that during the frequent times that the generator would cease to function properly, residents requiring oxygen were switched to portable oxygen tanks, residents who are on specialized air mattresses were converted to standard mattresses, and eventually they were able to reach the emergency kits which were behind locked doors and inaccessible at the beginning of the power outage to pass out some flashlights to staff while others used their personal phones as flashlights. The NHA also stated that they were unable to access residents' electronic medical records (EMRs) during this time as the computer back up battery was not functioning. The NHA confirmed that residents did not receive flashlights or bells/whistles to be able to communicate with staff. The NHA also confirmed she was unable to initially be present during the beginning stages of this ice storm event so no one had access to the door with all the emergency supplies. Review of the facility's Initial Actions read, in part, Communication Failure: .Distribute Bells and whistles to staff and identified residents to use as audible emergency notice and/call light needs. Review of the facility's Access to and Security of Facility During Emergencies read, in part, To ensure that keys to locked rooms are available during emergency situations, the person in charge during the administrator's absence shall have access to keys of all locked rooms or areas . (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Emergency Equipment read in part, The facility has designated certain equipment for use during emergency conditions. All such equipment is located in the following areas: Maintenance Office . the maintenance department will be responsible for maintaining emergency equipment and ensuring that it is operable at all times .Emergency equipment, as a minimum, consists of the following: A) Flashlights B) Ropes C) First Aid Kits D) Portable fire extinguishers E) Radios F) Batteries .