STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Wyoming	625 36th Street SW Wyoming, MI 49509

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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** Based on interview and record review, the facility failed to treat a urinary tract infection in a timely manner for one of one resident's (Resident #1) reviewed for the quality of care. Findings:Resident #1 (R1)Review of an admission Record revealed R1 was a [AGE] year-old male, last admitted to the facility on [DATE], with pertinent diagnoses of pneumonia and limitation of activities due to disability and use of a foley catheter (a system that drains urine from the bladder into a collection bag) long term. Review of a physician communication book revealed that nursing staff had left a note for the facility prescribers on 12/07/25 that R1 was complaining of pain in his penis area. Review of a prescriber note for R1, written on 12/08/25 by Nurse Practitioner (NP) W reflected the following concern: (R1) is seen today for penile pain. He feels it is related to the catheter. Resident has a chronic indwelling foley .white to green drainage noted around the foley catheter and dark cloudy urine in the foley collection bag. Plan: check a urinalysis with culture and sensitivity if indicated. Resident with penile pain. Foley needs to be changed every 30 days. Excessive amount of penile drainage, urine is cloudy and looks suspicious for a UTI (urinary tract infection). Review of an Order Summary for R1 revealed an order for the urinalysis (U/A) and culture and sensitivity (C&S) on 12/08/25. Review of a prescriber note for R1, written on 12/10/25 by NP W reflected the following concern: (R1) seen today for right flank pain, recent malodorous (bad smelling) drainage around the catheter, U/A is pending for this. Plan: will wait for U/A and C&S ordered earlier this week. PA W was not made aware by nursing that the urine had not yet been collected from R1 for the U/A and C&S. Per the Electronic Health Record (EHR) the U/A and C&S for R1 were not collected by staff until 12/11/25 and the C&S had been completed incorrectly and could not be resulted. Documentation could not be found that NP W was notified. Review of a physician note for R1, written on 12/12/25 by Medical Doctor (MD) PP reflected: (R1) had a urinalysis (U/A) with culture and sensitivity on 12/08, results not seen at this time. Review of a prescriber note for R1, written on 12/15/25 revealed that R1 was seen for redness to his right third toe. The note does not contain any information related to the U/A and culture and sensitivity that the lab was not able to complete. Review of a nursing progress note, dated 12/15/25 at 11:30 PM, reflected that R1 asked to be sent to the emergency room for care for penile pain and discharge. Review of an After Visit Summary for R1, dated 12/16/26, from the emergency room revealed that R1 had been diagnosed with a urinary tract infection and was prescribed an antibiotic.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a fall in two of two residents (Resident #1 and Resident #51) and secure hazardous materials and biologicals in one of one salon and for one resident (Resident #43) reviewed for accidents and hazards, resulting in fractures for R1 and R51 residents and the potential for R43 to ingest hazardous materials.Findings Include: Resident #1 (R1) Review of an admission Record revealed R1 was a [AGE] year-old male, last admitted to the facility on [DATE], with pertinent diagnoses of pneumonia and repeated falls. Review of a Facility Investigation initiated for R1 after a fall with a major injury on 12/30/25 concluded the following: the evening of 12/30/25 Certified Nurse Aide (CNA) LL was in R1's room providing care. CNA LL did not use a second staff person for safe bed mobility and R1 fell from the bed onto the floor causing a cut to the forehead and a broken right distal femur (above the knee). After the incident, CNA LL reported knowing that R1 required two people for safe bed mobility but proceeded anyway. This incident represents a failure to follow the resident's care plan. Review of a Care Plan for R1 reflected the following safety intervention: Bed mobility: two-person assist. During an interview on 01/06/26 at 3:29 PM, the Director of Nursing indicated that CNA LL had not followed facility policy, and the resident centered care plan, and those actions led to the fall and fractured femur for R1. Resident #51 (R51)Review of an admission Record revealed R51 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses of cognitive communication deficit, difficulty walking, muscle weakness, and lack of coordination. Review of a Fall Report provided by the facility, revealed R51 sustained an unwitnessed fall in her room on the evening of 12/20/25. The report also indicated that R51 was transferred back to bed via a mechanical hoyer lift before she received a complete head-to-toe assessment by nursing staff. After being transferred back to her bed, R51 complained of right hip pain. R51 was sent to the emergency room and diagnosed with a right proximal femur fracture (just below the hip). During an interview on 01/07/26 at 4:07 PM, the Director of Nursing stated that Licensed Practical Nurse (LPN) HH had moved R51 from the floor to the bed while R51 complained of right hip pain and without first assessing R51 for injury. Review of the facility policy Fall Management Guidelines revealed the following procedure for a post-fall evaluation: if a resident has just fallen or is observed on the floor without a witness to the event, evaluate for possible injuries of the head, neck, spine, and extremities (arms and legs). During an observation on 01/06/25 at 08:46 AM, the beauty shop door sat open, and the white cabinets were unlocked and contained an aerosol can of [NAME] Cool Air Plus, labeled as a coolant, disinfectant, lubricant, cleaner, and rust preventative that was hazardous to humans. Also, in an unlocked cabinet sat a can of hair spray. Resident #43 (R43) Review of an admission Record revealed R43 was an [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of insomnia, anxiety disorder, and repeated falls. During an observation on 01/05/26 at 10:52 AM a bottle of Dermal Wound Cleaner, that read call poison control if swallowed, sat on the round table in R43's room. Also, in R43's room were a 7.5-ounce bottle of Kleen peri cleaner and a prescription bottle of Miconazole 2% powder.

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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** This citation pertains to Intake 2629685Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include:On 01/05/2026 at 9:06 AM, observed hand towels were not readily available at the handsink in the dishwashing room. This is the only designated handsink for the kitchen. According to the 2022 FDA Food Code section 6-301.12 Hand Drying Provision.Each HANDWASHING SINK or group of adjacent HANDWASHING SINKS shall be provided with:(A) Individual, disposable towels; Pf (B) A continuous towel system that supplies the user with a clean towel; Pf or (C) A heated-air hand drying device; Pf or (D) A hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures. PfOn 01/05/2026 at 9:10AM, observed filters were not in the face of the hood ventilation system, over the cookline. On 01/05/2026 at 9:20AM, during interview, Dietitian DD stated the filters have been out of the hood system for cleaning since Friday 1/2/2026. Dietitian DD stated the hood was not operational and Dietitian DD was observed turning off the hood. According to the 2022 FDA Food Code Section 4-301.14 Ventilation Hood Systems, Adequacy. Ventilation hood systems and devices shall be sufficient in number and capacity to prevent grease or condensation from collecting on walls and ceilings.On 01/05/2026 at 9:27AM, observed resident's food, an orange/brown colored sauce in foam takeout container, with a date of 12/31/2026. Resident's foods are stored in the pantry refrigerator. At that time interview with Dietitian DD stated that the facility policy was to hold the time/temperature controlled for safety food for 3 days and then discarded. On 01/05/2026 at 10:00AM, Vital therapeutic nutrition supplement product observed with an expiration date of 1 [DATE], product was sitting on shelving in back room with other therapeutic nutrition supplemental products. According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) .On 01/05/2026 at 9:34AM, observed in dining room, the handsink was leaking. The water that was leaking was cold water. Dietitian DD stated the faucet was repaired the week prior for same issue. According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.On 01/05/2026 at 10:00AM, it was observed that various kitchen personnel were leaving other tasks and then handling clean dishes without washing their hands. Personnel were also observed taking off their gloves and not washing hands before putting on new gloves.On 01/05/2026 at 11:00AM, observed several kitchen personnel leave the kitchen area, come back into kitchen and begin working with equipment to prepare for lunch without washing their hands. According to the 2022 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and:(A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.On 01/05/2026 at 10:05AM, observation of dish machine operation, disclosed the sanitizing rinse was not reaching 180 degrees F on the gauge readout and not reaching a plate surface temperature of 160 degrees F. Plate surface temperature was tested using a DishTemp plate simulating tester. The reading on the tester was a maximum temperature of 146 degrees F. Interview with Dietitian DD at this time, regarding temperatures and procedures for dish machine operation, confirmed the minimum temperatures of 180 degrees F hot water at gauge readout and 160 Degrees F for plate surface temperature. According to the 2022 FDA Food Code Annex 3. Public Health Reasons/Administrative Guidelines section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multiuse utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least 71 C (160 F) as measured by an irreversible registering temperature measuring device to affect sanitization. When the sanitizing rinse temperature exceeds 90 C (194 F) at the manifold, the water becomes volatile and begins to vaporize reducing its ability to convey sufficient heat to utensil surfaces. The lower temperature limits of 74 C (165 F) for a stationary rack, single temperature machine, and 82 C (180 F) for other machines are based on the sanitizing rinse contact time required to achieve the 71 C (160 F) utensil surface temperature. According to the 2022 FDA Food Code section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90C (194F), or less than: (1) For a stationary rack, single temperature machine, 74C (165F); or (2) For all other machines, 82C (180F).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 1.) provide care following professional standards of practice and facility policy to prevent the development of a injuries and 2.) assess, monitor, and provide ordered treatment for residents with pressure injuries/wounds for 2 residents (Resident #58 and #43) out of 18 residents reviewed for pressure injury prevention/management.Findings:Resident #43 (R43) Review of an admission Record revealed R43 was an [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of a stroke causing paralysis and weakness on the resident's left side. During an observation on 01/07/26 at 9:45 AM, Certified Nurse Aide (CNA) P provided morning care for R43 and a dressing on R43's coccyx area was in place. The dressing had writing on it in blue maker, the date 1/4, and also written on the dressing in black marker were the dates 1/6 and 1/7. The Director of Nursing was called to R43's room to observe the multiple dates written on the dressing. The DON observed the dressing and stated that it looked like the dates had been changed on the dressing so that it wouldn't have to be changed. Review of an Electronic Treatment Administration Record (Etar) for R43, dated January 2026, revealed an order to clean open area on coccyx with normal saline, pat dry, and apply Optiform for protection every night shift every other day starting 01/04/26. There was no documentation that showed the dressing had been changed on 01/06/26. Review of a Care Plan for R43 reflected: Resident has pressure ulcer and . administer treatments per physician orders. Resident #58 (R58) Review of an admission Record revealed R58 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: stroke, abnormal weight loss, and cerebral palsy. Review of R58's Braden Scale-for Predicting Pressure Ulcer Risk Evaluation dated 12/5/25 indicated R58 was a High Risk for developing a pressure injury. The evaluation dated 12/14/25 and 12/21/25 revealed R58 was a moderate risk for developing a pressure injury. During an observation on 01/05/2026 at 9:31 AM, R58 was in bed on her back with her heels elevated off the bed. There were no pillows/offloading devices behind her left or right side to reduce pressure and prevent the worsening of her skin injury. During an observation on 01/05/2026 at 11:23 AM, R58 was in bed on her back with her heels elevated off the bed. There were no pillows/offloading devices behind her left or right side. During an observation on 01/05/2026 at 1:12 PM, R58 was in bed on her back with her heels elevated off the bed. There were no pillows/offloading devices behind her left or right side. During an observation on 01/05/2026 at 2:26 PM, R58 was in bed on her back with her heels elevated off the bed. There were no pillows/offloading devices behind her left or right side. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 01/05/2026 at 4:04 PM, R58 was in bed on her back with her heels elevated off the bed. There were no pillows/offloading devices behind her left or right side. During an observation on 01/06/2026 at 8:38 AM, R58 was in bed with her heels elevated. There was a pillow slightly under her left side. R58 was not positioned in a way to fully offload pressure on her buttocks. During an observation on 01/06/2026 at 11:46 AM, R58 was in bed with her heels elevated. There was a pillow slightly under her left side. R58 was not positioned in a way to fully offload pressure on her buttocks. During an observation on 01/06/2026 at 9:47 AM, R58 was in bed with her heels elevated. There was a pillow slightly under her left side. R58 was not positioned in a way to fully offload pressure on her buttocks. Review of R58's Skin-Total Body Eval (to be completed weekly) revealed the last evaluation was completed on 7/27/25. Review of R58's Hospice Note dated 12/24/25 revealed, .skin open of left side (about 1 inch diameter) of buttocks near coccyx. LPN (Licensed Practical Nurse [name omitted]) and this RN (Registered Nurse) assess, and foam dressing applied. (LPN) to update plan of care, and alert doctor . Review of R58's Nursing Progress Note dated 12/24/2025 revealed, hospice rn in, open area noted lt. (left) buttock, nearly open rt. (right) buttock, (provider group) and wound team notified, foam border dressing applied. Review of the Provider Communication Log dated 12/24/25 revealed R58 had (left) buttock-open area and (right) buttock-nearly open with a foam border applied. Review of R58's Electronic Medical Record revealed no documentation that a comprehensive wound assessment was conducted at the time the skin breakdown/pressure injury was identified. (Comprehensive wound assessments are to include location, dimensions, description of wound bed, exudate type, exudate amount, presence of odor, wound edges, peri-wound assessment, tunneling/undermining, and pain.) Review of R58's Order Summary dated 12/25/25 revealed, foam border dressing to bilat. (bilateral) buttocks wounds, change daily and prn (as needed) dysruption (sic) every day shift for wound care. Review of R58's January Treatment Administration Record (TAR) revealed the foam boarder dressing change was not completed on 1/2/26 or 1/3/26. Review of R58's Skin Issues (wound evaluation) dated 1/8/26 at 11:39 AM revealed a new wound, In-house acquired, Open lesion on the left coccyx measuring 1.8 cm (length) x 1.38 cm (width) x 0.1 cm (depth). (Completed 15 days after the wound was discovered.) Review of R58's Care Plan revealed no documentation of the pressure injury identified on 12/24/25 or any newly implemented interventions to prevent further breakdown. R58's skin integrity Care Plan was last updated on 10/22/23. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R58's Care Plan revealed: Focus: (R58) has limited physical mobility r/t: -Comorbidities: Cerebral palsy, left-sided weakness and dysarthria following intracerebral hemorrhage (stroke), and history of left hip fracture. Interventions/Task.BED MOBILITY: (R58) requires extensive assist by 2 staff to turn and reposition in bed. Date Initiated: 02/14/2023 (Confirming R58 relied on staff assistance to offload pressure to prevent a pressure injury). AND Focus: (R58) has potential for impairment to skin integrity Goal: (R58's) skin integrity breaks will exhibit healing by next review date. Date Initiated: 03/16/2023 (Indicating R58 had a history of skin breakdown. Additionally, R58's Care Plan had not been updated when the previous skin injuries healed. Interventions/Task.Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (Medical Doctor). Date Initiated: 11/21/2022. R58's Care Plan did not include a turning/repositioning schedule or the use of offloading devices. (No new interventions implemented since 10/22/23.) On 01/08/2026 at 10:40 AM a request was made via email for interventions implemented for R58's skin breakdown identified on 12/24/25 was requested. No documentation was received prior to survey exit confirming R58's care plan had not been updated. During an interview on 01/08/2026 at 12:55 PM, the Director of Nursing (DON) reported skin assessments were to be completed weekly on all residents and confirmed R58 had not had a skin assessment since July. During an interview on 1/8/25 2:22 PM, Unit Manager/Licensed Practical Nurse (UM/LPN) II reported she had not been made aware that R58 had a skin injury identified on 12/24/25 and the expectation was for licensed nurses to notify her and the management team of any new skin injuries. UM/LPN II reported that weekly skin assessments were now scheduled in R58's Electronic Medical Record, a comprehensive wound assessment was completed, and R58 would be evaluated by the wound provider. UM/LPN II reported education would be implemented regarding wound management and a facility wide audit was initiated for any missing treatments. Review of the facility policy Skin and Wound Guidelines last revised 3/20/24 revealed, Skin alterations and pressure injuries are evaluated and documented by the licensed nurse. Weekly evaluation of the skin alteration in the resident's medical record by the wound team or licensed nurse per state and federal regulations. Weekly evaluation of the pressure injury in the resident's medical record by the wound team or licensed nurse per state and federal regulations.The individualized comprehensive care plan addresses the resident's problem (i.e. at risk for skin breakdown or actual wound)/ the goal for prevention and/or treatment, and individualized interventions to address the resident's specific risk factors and the plan for reduction of risk. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, When you identify the presence of a skin wound or pressure injury, closer assessment is required. Assess the type of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure fluids were within reach for one of three residents (Resident #43) reviewed for hydration. Findings:Resident #43 (R43)Review of an admission Record revealed R43 was an [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of a stroke causing left sided paralysis and protein-calorie malnutrition. During an observation and interview on 01/05/26 at 12:19 PM, R43 sat up in bed eating lunch with the use of her right hand. When asked if R43 could reach the styrofoam cup of water positioned on the left side of the over bed table, R43 responded no but if you move that cup over here (pointed to the right side of the over bed table), I can reach it. During an observation on 01/06/26 at 9:35 AM, R43 laid in bed resting with her eyes closed. The styrofoam cup of water sat on the far-left corner of the over bed table, out of reach of the resident. During an observation on 01/06/26 at 11:14 AM, R43 laid in bed resting with her eyes open and the styrofoam cup of water sat on the far-left corner of the over bed table, out of reach of R43. During an observation on 01/06/26 at 3:20 PM, R43 laid in bed resting with her eyes open. The styrofoam cup of water sat on the far-left corner of the over bed table out of reach. When asked if she could reach the water cup, R43 attempted to reach across her body with her right arm and demonstrated that she could not reach the water cup. During an observation on 01/07/26 at 8:20 AM, R43 activated the call light system and stated that she was thirsty and wanted a drink but could not reach the cup of water that sat on the left side of the over bed table. Review of R43's Care Plans revealed she did not have a treatment plan in place that addressed her left sided paralysis and inability to reach with her left hand and her need to have hydration positioned so R43 could reach it with her right hand.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician orders for one of two resident's (Resident #93) reviewed for tube feeding. Findings:Resident #93 (R93)Review of an admission Record revealed R93 was a 65- year-old female, admitted to the facility on [DATE], with pertinent diagnoses of a new PEG (percutaneous endoscopic gastrotomy) tube placed on 12/29/25, following a stroke that caused right sided weakness and difficulty swallowing. During an observation on 01/05/26 at 12:32 PM, the 60-milliliter (ml) syringe used for tube feed flushes sat in the graduated basin with the barrel in the syringe and not separated, after cleaning it to air dry. R93 stated I need a drink. During an observation on 01/05/26 at 4:04 PM, R93's tube feed ran and the head of the bed (HOB) was positioned at 10 degrees. The tube feed formula bag did not have the date and time the feed was initiated nor the physician ordered rate. During an interview on 01/06/26 at 8:47 AM, R93 asked for something to drink. During an observation on 01/06/26 at 3:40 PM, R93 sat up in a Broda chair near the nurse's desk. R93 stated she was very thirsty. During an observation on 01/07/26 at 8:16 AM, R93 laid in bed resting with her eyes closed. The tube feed ran at the physician ordered rate and was almost empty. However, the kangaroo flush bag (how the resident receives hydration) was full. Per the infusion pump (an electronic device that was programmed by nursing to deliver tube feed nutrition and water flushes at a physician ordered rate) a flush rate had not been set and R93 was not receiving any hydration since the tube feed was initiated at 4 PM on 01/06/26. The previous tube feed run ended at 8:00 AM on 01/06/26 and R93 had not received any fluids/hydration in the past 24 hours. The 60-milliliter syringe used for tube feed flushes sat in the graduated basin with the barrel in the syringe, not separated, and the graduated container was dated 01/06. During an interview on 01/07/26 at 8:59 AM, Licensed Practical Nurse (LPN) T reported having started the tube feed and hydration flush for R93 yesterday (01/06) afternoon and did not double check to ensure the hydration flush was programmed and running. During an observation on 01/08/26 at 8:17 AM, R93 laid in bed resting with her eyes closed and the tube feed running. The syringe and graduated basin for flushes was dated 01/06 and the barrel was in the syringe. The tube feed formula bag did not have the date and time the feed was initiated nor the physician ordered rate. Review of an Electronic Medication Administration Record (Emar) for R93 dated January 2026 reflected the following physician orders: (a) Tube feed order .flush with water 50 ml's every 1 hour while tube feed is infusing and flush with 60 ml's of water after each feeding, and (b) elevate HOB to 30 to 45 degrees at all times during tube feed. There was no documentation on the Emar that indicated nursing signed off on these two orders the evening of 01/02/26. Review of the facility policy Tube Feeding reflected .the tube feed formula/flushing 60 ml (milliliter) syringe will be dated and changed every 24 hours .after using the 60 ml syringe, clean with warm/hot water and dry. The plunger is not reinserted into the barrel and is stored dry in a container for the next use .on the formula bag document the date and time the formula was hung/administered and the physician ordered rate of administration .position the head of the bed at least 30 degrees for tube feeding.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2665891Based on observation, interview, and record review, the facility failed to follow professional guidelines for two of two resident's (resident #72 and Resident #91) reviewed for peripheral and central intravenous fluids. Findings:Resident #72 (R72)Review of an admission Record revealed R72 was a [AGE] year-old female, originally admitted to the facility on [DATE] with pertinent diagnoses of a right femur fracture. R72 was most recently hospitalized on [DATE] to 12/10/25 for an infected prosthesis in the right femur and had a central catheter placed to receive intravenous antibiotics. During an observation on 01/05/26 at 11:30 AM, R72 sat in a chair with an IV (intravenous) antibiotic hanging on an IV pole and the antibiotic was connected to a PICC (percutaneously inserted central catheter) in R72's right arm. R72 stated that the tubing that delivered the antibiotic fluid to the PICC was stuck inside the lumen (opening) of the PICC and nursing could not get it out. They have called in a specialty nurse for it. During the same observation, it was noted that a folded-up gauze dressing was covering the catheter at the site it entered the skin, this dressing was visible through the clear dressing (opsite) covering the entry site of the PICC. R72 stated that the dressing for the PICC line had just been changed by nursing. Review of an Electronic Treatment Administration Record (Etar) for R72, dated January 5th, 2026, revealed that there was not a measurement of the PICC external catheter for nursing to monitor daily. The measurement would alert nursing if the catheter had been moved at all from its original placement. During an interview on 01/05/26 at 11:49 AM, Unit Manager/Licensed Practical Nurse (UM/LPN) II indicated that she had completed a PICC line dressing change that morning for R72 and also reported that there were no measurements available regarding the length of R72's PICC. UM/LPN II stated that a specialty vascular access nurse had been called in the evaluate the tubing that had been stuck into the lumen of the PICC. Antibiotic therapy for R72 had been paused until the PICC was evaluated further. During an interview on 01/05/26 at 2:20 PM, Vascular Access specialty Registered Nurse (RN-VA) BB evaluated R72's PICC and indicated that the IV tubing had been incorrectly pushed into the opening of the PICC instead of using a needless connector. RN-VA BB was able to safely remove the IV tubing from the opening of the PICC and then proceeded to remove the dressing. The end of the catheter was coiled up and covered by a folded gauze dressing, and the insertion site at the skin could not be seen without removing the dressing. RN-VA BB indicated that the gauze dressing should not be under the clear sterile PICC dressing as it was a medium (a good environment) for bacterial growth. The gauze dressing also obscured (blocked) the nurses from seeing how long the PICC was from the skin to the needless connector (which would let nursing know if the catheter had moved). RN-VA BB stated this was an important measurement for nursing to know because the tip of the PICC was placed in a blood vessel very near to heart and if it moved, it could have serious consequences. Resident #91 (R91) Review of an admission Record revealed R91 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses of metabolic encephalopathy (altered mental status) due to sepsis (a blood infection) and had a central catheter placed to receive intravenous (IV) antibiotics. Review of an admission assessment dated [DATE], for R91 revealed the resident was admitted to the facility with a PICC placed in the left arm. The Assessment did not have any information regarding the size and length of the catheter, the circumference of the arm at the catheter insertion site, and how the PICC line site appeared, ie was the dressing intact, any redness or other signs of infection etc. Review of an Electronic Medication Administration Record (Emar) revealed an order for R91 to receive IV antibiotics every 8 hours for 28 days until 11/25/25. Review of an Etar for R91 dated October 2025 revealed there were no orders for nursing to monitor the PICC site, to change dressings weekly and as needed, to monitor for signs and symptoms of infection, monitor the length of the catheter, and flushing the catheter. During an interview on 01/08/26 at 10:30 AM, Physician Assistant (PA) W stated that if the hospital does not sent orders regarding the monitoring of the catheter (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(PICC), flushing, etc the nurses should recognize this and call for orders. Review of a Nursing Progress Note for R91, dated 11/1/25 revealed .per report, PICC pulled by Registered Nurse/Unit Manager/Infection Control Preventionist Z because IV med was discontinued. During the same interview on 01/08/26 at 10:30 AM, Physician Assistant (PA) W indicated that an order to stop IV antibiotics and pull the PICC line were not given. Review of the facility policy IV Therapy Peripherally Inserted Central Catheter (PICC) reflected .Length of the catheter is specific to the resident. The length needs to be documented in the medical record .this is a very fragile catheter and can be broken easily .and the upper arm circumference should be measured on admission and weekly to monitor for infiltration.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to account for controlled substances in one of one medication carts reviewed for narcotic reconciliation. Findings:Review of the Controlled Medication Shift Change Log for the medication cart Medbridge 1 revealed an incorrect total was documented on 1/3/26 at 7:30 AM. That incorrect total was carried forward through the next four shift change counts. Review of the Controlled Substance Shift Inventory sheets for the medication cart Medbridge 1 dated 11/22/25 to 12/30/25 revealed the following:Two nurses' signatures were not documented on (a) 11/25 at the 7 PM count, (b) 11/30 at the 7 AM count, (c) 12/04 at the 3 PM count, (d) 12/8 at the 3 PM count 12/16 at the 7 PM count, and on 12/19 at the 7 AM count. An end of shift total was not documented on (a) 11/25 at 11:15 PM, (b) 11/29 at 7 AM, (c) 12/1/ at 3 PM, (d) 12/3 at 7 PM, (e) 12/4 at 3 PM, (f) 12/10 at 7 PM, and (g) 12/11/ at 7 AM. Incorrect counts were noted on (a) 11/22 at 7 PM, (b) 11/28 at 7 PM, (c) 12/1 at 7 PM, (d) 12/2 at 7 AM, (e) 12/18 at 7 am, and (f) 12/29 at 7 PM. During an interview on 01/08/26 at 1:40 PM, the Director of Nursing (DON) indicated that Unit Manager/RN Z was in charge of auditing the controlled substance documentation on the medication carts. The DON also stated, after reviewing the above findings, that the documentation was not the policy nor expectation of the facility. Review of the facility policy Controlled Medication Guidelines reflected: .A physical inventory of all controlled medications is completed by two licensed nurses and is documented on the shift-to-shift form at shift exchange or whenever a nurse relinquishes their keys to another nurse and .the two nurses sign the shift-to-shift count sheet acknowledging that the actual count of controlled medication matches the quantity documented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to 1) implement an effective and current system of surveillance of staff illnesses to identify possible communicable diseases and infections to prevent the spread of an illness/outbreak, 2.) ensure appropriate personal protective equipment (PPE) for a resident in contact precautions, and 3.) ensure residents at risk of MDRO (multi-drug resistant organisms) acquisition were placed in enhanced barrier precautions for 3 residents (Resident #36, #58, and #40) out of 18 residents reviewed for infection prevention and control.Findings: Review of the December Employee Illness Log revealed: Certified Nursing Assistant (CNA) OO called off of work with an onset date of 12/4/25 for the reason of just said not feeling well. There was no documentation of specific symptoms or a return to work date. CNA LL called off of work with an onset date of 12/26/25 for the reason of none listed. There was no documentation of specific symptoms or a return to work date. CNA MM called off of work with an onset date of 12/27/25 for the reason of unknown. There was no documentation of specific symptoms or a return to work date. CNA NN called off of work with an onset date 12/31/25 for says stomach bug. There was no documentation of specific symptoms or a return to work date. All 32 employee illness call-offs for the month of December did not have a return to work date. During an interview on 01/07/2026 at 10:14 AM, Infection Control Preventionist (ICP) Z and the Director of Nursing (DON) reported that the process for employee call-offs was for the facility staff to fill out a slip with the employee name, shift, and illness/symptoms and place that in the schedulers bin. The scheduler would then document that absence and provide ICP Z with the slip. ICP Z reported call-offs were tracked in real time and discussed each morning. If the reason for the call-off was vague she was responsible for following up to obtain accurate symptoms and provide a return to work date. During an interview on 01/08/2026 at 11:16 AM, the Director of Nursing (DON) reported that the Infection Control Preventionist (ICP) was new to the position and there had been some areas missed. The DON was notified that specific illnesses and return to work dates were not completed/acted upon and she confirmed that the investigation of specific symptoms and a return to work date should have been completed. Resident #36 (R36) Review of an admission Record revealed R36 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: surgical wound to the right foot. Review of R36's Order Summary dated 11/3/25 revealed, Right foot surgical site: cleanse with saline and gauze, apply dry gauze over the site, secure with kerlix then ACE wrap. Change daily. note and s/s of infection. every day shift for surgical site care Note there is a skin substitute stapled to the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound base, DO NOT REMOVE THIS! Just cleanse gently over the top and around the wound. Further review of R36's Order Summary revealed no order for R36 to be in Enhanced Barrier Precautions (EBP) due to her right foot wound. Resident #58 (R58) Review of an admission Record revealed R58 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: stroke, abnormal weight loss, and cerebral palsy. Review of the Provider Communication Log dated 12/24/25 revealed R58 had (left) buttock-open area and (right) buttock-nearly open with a foam border applied. Review of R58's Order Summary dated 12/25/25 revealed, foam border dressing to bilat. (bilateral) buttocks wounds, change daily and prn (as needed) dysruption (sic) every day shift for wound care. Further review of R58's Order Summary revealed no order for R58 to be in EBP due to the wound on her coccyx. During an observation on 01/07/2026 at 1:25 PM, there was no EBP signage posted outside of R36 and R58's room. During an observation on 01/08/2026 at 10:52 AM, there was no EBP signage posted outside of R36 and R58's room. During an interview on 01/08/2026 at 10:56 AM, Licensed Practical Nurse (LPN) U reported that R58 was not in EBP, and if she was, there would be signage on her door to alert staff to wear appropriate PPE (personal protective equipment) when performing tasks. LPN U reported that the ICP was responsible for apply the signage on the doors. During an interview on 01/08/2026 at 11:16 AM, the DON was notified that R58 and R36 both required wound care but were not in EBP. The DON confirmed the ICP is responsible for ensuring residents were placed in EBP and that appropriate signage and PPE was placed outside of the room. Review of the CDC guidance (dated 6/28/24), Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). In the guidance, wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. Review of the facility policy Infection Control Surveillance last revised 9/25/24 revealed, .The infection preventionist or designee will utilize surveillance tools to recognize the occurrence of infections, record their number and frequency, detect outbreaks and epidemics/ monitor employee infection, monitor adherence to infection prevention and control practices, and detect unusual pathogens with infection control implications. On 1/7/26 at 11:48 AM a request for policy for employee call-offs was requested. The policy did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	include tracking off illnesses or return to work criteria. Review of the State Operations Manual revealed the infection control surveillance, Establishes facility-wide systems for the prevention, identification, reporting, investigation and control of infections and communicable diseases of residents, staff, and visitors. It must include an ongoing system of surveillance designed to identify possible communicable diseases and infections before they can spread to other persons in the facility and procedures for reporting possible incidents of communicable disease or infections. NOTE: For purposes of this guidance, staff includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. Enhanced Barrier Precautions (EBP) EBP are used in conjunction with standard precautions and expands the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following.Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. R40 A review R40's admission Record, dated 1/6/26, revealed R40 was a [AGE] year-old resident that was admitted to the facility on [DATE]. In addition, R40's admission Record revealed multiple diagnoses that included contacted with and suspected exposure to COVID-19. A review of a sign posted onto the outside of R40's door on 01/06/2026 at 8:45 AM, revealed R40 was in isolation and Special Droplet Contact Precautions (gown, gloves, face shield, and N95 respirator) were to be followed for anyone entering R40's room. During an observation on 01/06/2026 at 8:45 AM, Maintenance Assistant (MA) A was observed going into Resident #40's room with a blue surgical mask on. The sign posted on the outside of Resident #40's room door revealed, Special Droplet Contact Precautions and advised anyone entering the room to wear a gown, gloves, face shield, and N95 respirator. MA A also left the room door open approximately 3 inches so the surveyor could see him standing next to R40's bed talking with him. The sign on the door also instructed staff, visitors, and physicians (doctors) to keep the room door closed. MA A was in R40's room for approximately 5 minutes. During an interview on 01/06/2026 at 8:50 AM, MA A stated he was aware that R40 had a sign on his door revealing he was in Special Droplet Contact Precautions. MA A verbally confirmed that anyone going into R40's room should wear a gown, glove, N95 respirator, and face shield. During an interview on 01/06/2026 at 8:55 AM, Certified Nursing Assistant (CNA) B verified that R40 was in isolation and Special Droplet Contact Precautions were to be followed for anyone entering R40's room. CNA B also stated R40 was in isolation for COVID-19. A review of R40's Provider encounter note, dated 12/20/25, revealed, Patient is seen for COVID-19 infection. Patient diagnosed over the weekend with COVID-19 tested positive on rapid testing here in facility due to symptoms of cough and nasal drainage. Patient is in bed. He does continue to complain of cough; his oxygen saturations are stable. Meds reviewed and vital signs are stable.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain general cleanliness and repair of ceilings and ventilation covers of resident restrooms 11, 12 and 13. Findings Include:On 01/15/2026 at 2:00PM, observed cobwebs on the vent's cover in the restrooms for rooms 11,12,13. Record review of Healthcare Services Group, Housekeeping schedule, states, Cleaning resident rooms using the 5 and 7 step cleaning process. The 5 and 7 step cleaning process lists what needs to be cleaned and cleaning methods for those steps, such as horizontal surfaces, vertical surfaces, dust mop and damp mop. On 1/05/2025 at 2:00PM, observed in room [ROOM NUMBER]'s restroom, the ceiling tile is sagging and partially off the ceiling grid tracks allowing for an accessible space of half inch between the tile and the track. On 01/05/2026 at 3:15PM, interview with Maintenance CC disclosed they were unaware of the ceiling tile sagging in room [ROOM NUMBER]'s restroom.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake #2674209Based on interview and record review, the facility failed to treat one resident (Resident # 72) in a dignified manner, out of three residents reviewed for dignity and respect. Findings: Resident #72 (R72) Review of an admission Record revealed R72 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses of an infected right hip replacement and difficulty walking. During an interview on 01/05/26 at 11:26 AM, R72 reported the following details regarding an incident that occurred very early in the morning on 11/12/25, that involved R72 and Certified Nurse Aide (CNA) Y: (a) during the night/early morning of 11/12/25 CNA Y came into her room and told R72 to stop putting on her call light and that CNA Y had been into R72's room multiple times tonight and was not coming back again, (b) R72 stated that CNA Y then messed around with her bed control and call light and left the room, (c) R72 fell back asleep, woke up sometime around 5 AM and needed to go to the bathroom, (d) R72 looked for and could not find her call light, (e) R72 had a bowel movement and urinated in her undergarments because she could not find the call light to alert staff that she needed help, and (f) R72 reported that she was devastated and embarrassed by the incident and was tearful when recounting the details of the incident. It felt like she (CNA Y) didn't come back on purpose to punish me. R72 stated that she finally got help from CNA S after shift exchange. During an interview on 01/06/25 at 12:35 PM, CNA S reported that entering R72's room the morning of 11/12/25 and could smell feces and that R72 was very upset. CNA S indicated that R72's sheets were saturated with urine and feces and that the call light was wrapped up with the bed remote, on the floor, out of sight and out of reach of the resident. CNA S recalled that R72 was embarrassed about the incident. CNA Y no longer worked at the facility and could not be reached for comment.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Wyoming	625 36th Street SW Wyoming, MI 49509

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights remained within reach for three of three resident's (Resident #43, Resident #93, and Resident #10) reviewed for accommodation of needs. Findings:Resident #43 (R43)Review of an admission Record revealed R43 was an [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of a stroke that caused left sided weakness and paralysis, a history of falls, and lack of coordination. During an observation on 01/05/26 at 8:58 AM, R43 laid in bed with her eyes open. When asked if she could locate her call light, R43 looked around her bed and stated that she could not find it. The call light sat on the floor under the head of the bed, out of sight and out of reach of R43. During an observation on 01/05/26 at 10:57 AM, R43's call light remained on the floor under the head of the bed, out of sight and out of reach. During an observation on 01/05/26 at 12:01 PM, R43's call light laid on the floor under the head of the bed, out of reach and out of sight. Review of a Care Plan for R43 reflected the following intervention: (R43) will use the call light to call for assistance. Resident #93 (R93) Review of an admission Record revealed R93 was a 65- year-old female, admitted to the facility on [DATE], with pertinent diagnoses of a new PEG (percutaneous endoscopic gastrotomy) tube placed on 12/29/25, following a stroke that caused right sided weakness and difficulty swallowing. During an observation on 01/06/26 at 8:30 AM, R93 laid across the bed, legs off the right side of the bed, gown partially pulled up and stated, I want a drink. The call light laid on the floor at the right side of the head of bed, out of reach and out of sight of R93.During an observation on 01/08/26 at 8:25 AM, R93 laid in bed with her eyes closed, the tube feed ran, and the call light hung off the left side of the bed half-way to the floor, caught on the tube feed tubing pulling it taught from the resident to the infusion pump. The call light sat out of sight and out of reach of R93. Resident #10 (R10)Review of an admission Record revealed R10 was an [AGE] year-old female. During an observation on 01/05/26 at 1:58 PM, R10 sat up in bed awake and stated that if she needs anything she uses the call light system. R10 could not locate the call light at that time. The call light sat on the floor near the head of the bed out of sight and out of reach of the resident. During an interview on 01/08/2026 at 10:55 AM, Certified Nurse Aide (CNA) LP stated that the expectation for checking call light availability was that call lights were checked each time staff enter a room. Review of the facility policy Call Light Accessibility and Timely Response reflected .staff will be educated in the proper use of the resident call system, including how the system works and ensuring residents have access to the call light.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: 2664254Based on interview and record review, the facility failed to notify the provider of 1.) a change in condition and 2.) abnormal vital signs for 2 of 18 residents (Resident #90 and #81) reviewed for notification of change.Findings:Resident #90 (R90)Review of an admission Record revealed R90 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: type 1 diabetes mellitus with hyperglycemia.Review of a Facility Reported Incident (FRI) dated 9/17/25 revealed, (Hospital) patient navigator emailed facility to inform us that (R90) alleged he was being abused at our facility regarding his insulin management.Review of R90's Order Summary dated 8/6/25 revealed, Obtain Blood Sugar before meals and at bedtime before meals and at bedtime for blood glucose monitoring Less than 60 or greater than 200, notify physician.Review of R90's Blood Sugar Summary revealed:On 8/11/2025 at 9:49 PM, R90's blood sugar was 533 On 8/11/2025 at 10:50 PM, R90's blood sugar was 508 On 8/12/2025 at 1:27 AM, R90's blood sugar was 490 On 8/15/2025 at 11:23 PM, R90's blood sugar was 433 On 8/16/2025 at 7:14 AM, R90's blood sugar was 409 On 8/18/2025 at 10:09 AM, R90's blood sugar was 418 On 8/18/2025 at 10:20 AM, R90's blood sugar was 400 On 8/29/2025 at 7:44 AM, R90's blood sugar was 419 On 9/5/2025 at 11:15 PM, R90's blood sugar was 551 On 9/9/2025 at 11:29 AM, R90's blood sugar was 400 On 9/10/2025 at 4:52 PM, R90's blood sugar was 400Review of R90's Electronic Medical Record revealed no documentation that the provider was notified of the elevated blood sugar.During an interview via email on 01/08/2026 at 11:47 AM, a request for documentation that the provider had been notified of R90's elevated blood sugars was made. On 01/08/2026 at 12:15 PM, Nursing Home Administrator (NHA) stated, Unfortunately, we do not see anything documented either.During an interview on 01/08/2026 at 12:55 PM, the Director of Nursing (DON) reported that the expectation was for the licensed nurses to notify the provider of elevated blood sugars and that was typically done when a blood sugar reading was greater than 450.Resident #81 (R81)Review of an admission Record revealed R81 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and presence of cardiac pacemaker.Review of R81's Medication Administration Record revealed a dose of Nitroglycerin Sublingual Tablet was administered on 1/5/25 at 1:49 AM.Review of R81's Nursing Progress Note dated 1/5/2026 at 01:50 AM revealed, Patient complained of chest pain on left side nitroglycerin given. BP (blood pressure) 158/90 P(pulse) 73 R (respirations) 18 T (temperature) 97.3 Sats (Oxygen Saturation) 93% at room air. Nurse notified patient's wife of patient's condition and she stated to continue to monitor and she will be in this morning. Per Fundamentals of Nursing ([NAME] and [NAME]) 11th edition a myocardial infarction (heart attack) in men is usually described as crushing, squeezing, or stabbing. The pain is often in the left chest and sternal area.Review of R81's Nursing Progress Note dated 1/5/2026 at 2:31 AM revealed, Received call back from patient's wife CNA (Certified Nursing Assistant) reports patient resting quietly in bed. Patient's wife stated that if he becomes worse to send him to (name omitted) Hospital for evaluation.Review of R81's provider Progress Note dated 1/6/26 at 8:59 AM revealed he was assessed by the provider for elevated sugars.Review of R81's provider Progress Note dated 1/6/26 at 10:33 AM revealed he was assessed by the provider for emergency room and UTI (urinary tract infection) follow-up.Review of R81's Electronic Medical Record revealed no documentation that the provider had been notified of the episode of chest pain despite R81's complex history of heart disease and other comorbidities.Review of the Provider Communication Log revealed no documentation that the episode of chest pain was documented for provider follow-up.On 01/07/2026 at 2:07 PM, the Director of Nursing (DON) confirmed that there was no documentation that the provider had been notified of the episode of chest pain.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Be aware of the following common negligent acts that have (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resulted in lawsuits against hospitals and nurses (Frank and [NAME], 2019; Grant and [NAME], 2018): Failure to follow the standard of care Failure to communicate (e.g., failure to notify the health care provider of abnormal assessment data or significant changes in a patient's status) Failure to document care and evaluation of care provided to the patient Failure to assess and/or monitor, including making a nursing diagnosis. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: 2641157Based on interview and record review, the facility failed to 1.) prevent misappropriation of resident medication and 2.) monitor and investigate the potential/ongoing misappropriation of resident narcotic medication for 2 residents (Resident #38 and #41) out of 7 residents reviewed for the misappropriation of medications, resulting in the diversion of medications and the potential for ongoing diversion of medications. Findings:Resident #38 (R38)Review of an admission Record revealed R38 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: type 2 diabetes.Review of R38's Facility Reported Incident (FRI) dated 10/29/25 revealed, .Verified The allegation was supported by evidence collected during the investigation.On 10/28/25 (Registered Nurse [RN] GG) accepted the Ozempic from the pharmacy at 11:30pm and had it in her possession. She received the medication from pharmacy then attempted to get (Licensed Practical Nurse [LPN] KK) to co-sign with her. This was concerning to (LPN KK) as it was already in (RN GG's) possession. (LPN KK) reported this to the DON (Director of Nursing) at 06:40am on 10/29/25. When first shift arrived at 0700am the medication was unable to be located. (RN GG's) statement was that she couldn't be responsible for the Ozempic because it was not her assigned resident. Packing slips for all meds delivered were recovered-except for the Ozempic.(RN GG) was stated by multiple co-workers that she was often communicating/inquiring about medications for weight loss.RCA highlighted the need for controlled access to GLP1s (type of medication) due to cost which was immediately implemented and all licensed nurses were re-educated on the process.(RN GG) was called on 10/31/25 and 1/03/25. Messages were left and there was no response to the facility. This was an isolated incident in which the facility responded promptly and replaced the Ozempic at facility cost. There were no missed doses or delays. There was no harm to the resident (R38).Resident #41 (R41)Review of an admission Record revealed R41 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain in left and right knees.Review of a Minimum Data Set (MDS) assessment for R41, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R41 was cognitively intact. Review of R41's Order Summary dated 11/15/24 revealed, HYDROcodone-Acetaminophen (Norco) Tablet 5-325 MG Give 1 tablet by mouth every 12 hours as needed for breakthrough pain management.Review of R41's Controlled Drug Receipt/Record/Disposition Forms revealed that from 10/25/25-1/4/26 only 1 nurse (LPN HH) dispensed the Norco to R41. No other licensed nurses dispensed any tablets of Norco to R41.An entry between 12/22/25 and 1/3/26 indicated a correct count was completed indicating a tablet of Norco was missing and could not be accounted for.During an interview on 01/07/2026 at 8:31 AM, R41 reported she took pain medication at night which was effective in controlling her leg pain. R41 confirmed the medication was Tylenol and was scheduled (not administered as needed). R41 reported she did have an order for as needed pain medication (Norco) but never asks for it as her pain was controlled without it.During an interview on 01/07/2026 at 2:20 PM, the DON reviewed R41's Controlled Drug Receipt/Record/Disposition Forms and confirmed that only 1 nurse dispensing a narcotic appeared suspicious for narcotic diversion.During an interview on 1/7/26 at 3:47 PM, the NHA confirmed what R41 had reported of the scheduled evening Tylenol being effective for her pain control and not requiring the as needed Norco. The NHA reported LPN HH would be suspended pending a misappropriation/diversion investigation.Review of the facility policy, Controlled Medication Guidelines last revised 3/20/24 revealed, .Suspected tampered packages (i.e. vials without tamper evident caps or taped punch cards) and unresolved discrepancies in the count must be reported immediately as follows: Notify the DON, charge nurse/ or designee and the pharmacy. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies. Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	working when the discrepancy was noted. The DON, charge nurse, or designee must also report any loss of controlled medications where theft is suspected to the appropriate authorities such as local law enforcement. Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately monitor and ensure residents were free from adverse drug reactions for 1 of 5 residents (Resident #41) reviewed for psychotropic medication use.Findings:Resident #41 (R41)Review of an admission Record revealed R41 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Bipolar II Disorder, Schizoaffective Disorder, and Schizophrenia.Review of the FDA (Food and Drug Administration) recommended ANC (absolute neutrophil count) monitoring frequency for Clozaril (clozapine) (last revised 7/21/25) revealed, ANC Level Treatment Recommendation ANC Monitoring Weekly from initiation to 6 months Every 2 weeks from 6-12 months Monthly after 12 months(See reference below)Review of R41's Order Summary dated 10/10/24 revealed, cloZAPine Oral Tablet 100 MG and cloZAPine Tablet 50 MG (Clozaril) Give 100mg by mouth three times a day for schizophrenia hs (bedtime) dose is taken with 50mg to equal 150mg.Review of R41's Order Summary dated 4/15/25 revealed, CBC (complete blood count) q (every) 60 days dx (diagnosis): schizophrenia.Review of the pharmacy Physician Recommendations dated 4/23/25 revealed, It is recommended that ANC must remain at or above 1,500/mm3 during the course of treatment. -During the first 6 months of treatment, monitor the ANC weekly. -If ANC remains above the threshold, monitoring frequency can be reduced to every 2 weeks, and every 6 months can be further reduced to every 4 weeks.Residents last known ANC was 4858 as of 2/4/25. Please consider obtaining an updated ANC value Q4W (every 4 weeks). A checkmark was next to Continue CBC with Diff (differential) Q2M (every 2 months) and signed by the provider 5/14/25. A handwritten note on the document dated 5/15/25 revealed, set QM (every month) as lab doesn't have Q2M avail(able). OK (with) (provider initials).Review of R41's Order Summary did not reflect the order for monthly CBC with differential lab draws.Review of R41's contracted Psychiatry Note dated 9/9/25 revealed, .No changes recommended today but would recommend monthly monitoring of CBC while on clozapine. CBC results.ANC 6460 (07/22/2025).Review of R41's contracted Psychiatry Note dated 10/21/25 revealed, .There were no labs available for review at that time. Labs on 9/25/2025 show WBC 8.18, ANC 5680, which is within acceptable range for clozapine therapy. Met with IDT in behavior management meeting today to discuss symptoms, plan of care, and medications.Review of R41's contracted Psychiatry Note dated 12/2/25 revealed, .Recommend monthly CBC monitoring with clozapine; last documented ANC in September (2025).Review of R41's contracted Psychiatry Note dated 12/30/25 revealed, .Collaborated with staff and reviewed records. She has been doing well on her current clozapine dose and sertraline dose and is tolerating without adverse effects. No current labs are in her chart for review. Recommend monthly monitoring of CBC with clozapine use. Medical decision-making/risk: Ongoing management of severe persistent mental illness on clozapine requiring ongoing safety monitoring (CBC/ANC) .Review of R41's Laboratory Results revealed the last CBC resulted was on 9/25/25.On 01/06/2026 at 2:23 PM, a copy of the last 6 months of CBC's and/or ANC results was requested via email. On 01/06/2026 at 3:38 PM, the Nursing Home Administrator (NHA) reported there was no lab work available.During an interview on 01/08/2026 at 11:16 AM, the Director of Nursing (DON) reported the management team was unaware of the laboratory testing requirements for the administration of Clozaril and the pharmacy had not recently requested CBC or ANC results or routine testing.Review of the facility policy, Psychotropic Medication Use last revised 4/18/25 revealed, .The following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: *Antipsychotics *Anti-depressants *Anti-anxiety medications *Hypnotics. The physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with the resident/ their family and/or representative, other professionals, and the interdisciplinary team. Psychotropic medication (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	management includes: *Indications for use *Dose (including duplicate therapy) *Duration *Adequate monitoring *Preventing, identifying, and responding to adverse consequences.The effects of the psychotropic medications on a resident's physical/ mental/ and psychosocial well-being will be evaluated on an ongoing basis, such as In accordance with medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care.Leung J, [NAME] M, [NAME] R, [NAME] J, [NAME] O. AAPP Pharmacist Toolkit: Clozapine in Practice [Internet]. [NAME], NE: American Association of Psychiatric Pharmacists, 2022. [revised 2025 July 21]. Available from https://aapp.org/guideline/clozapine/updates.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update a care plan for 1 of 18 sampled residents (R40). Findings include: A review R40's admission Record, dated 1/6/26, revealed R40 was a [AGE] year-old resident that was admitted to the facility on [DATE]. In addition, R40's admission Record revealed multiple diagnoses that included contacted with and suspected exposure to COVID-19. A review of a sign posted onto the outside of R40's door on 01/06/2026 at 8:45 AM, revealed R40 was in isolation and Special Droplet Contact Precautions (gown, gloves, face shield, and N95 respirator) were to be followed for anyone entering R40's room. During an interview on 01/06/2026 at 8:55 AM, Certified Nursing Assistant (CNA) B verified that R40 was in isolation and Special Droplet Contact Precautions were to be followed for anyone entering R40's room. CNA B also stated R40 was in isolation for COVID-19. A review of R40's Provider encounter note, dated 12/20/25, revealed, Patient is seen for COVID-19 infection. Patient diagnosed over the weekend with COVID-19 tested positive on rapid testing here in facility due to symptoms of cough and nasal drainage. Patient is in bed. He does continue to complain of cough, his oxygen saturations are stable. Meds reviewed and vital signs are stable. A review of R40's care plans, dated 8/13/24 to 1/6/26, revealed R40 only had one care plan for any type of barrier/isolation precautions and that was for Enhance Barrier Precautions (cleaning hands when entering and leaving the room and gown and gloves only when conducting high contact resident care activities) (dated 9/20/24). R40 did not have an updated care plan for Special Droplet Contact Precautions even though he was diagnosed with COVID-19 on, or around, 12/20/25 (17 days prior to the observation). A review of R40's Kardex (a form that staff that provide care to residents use), dated 1/6/26, failed to reveal that R40 was on any type of contact precautions (Enhanced Barrier or Special Droplet Contact). On 1/6/26 at 4:15 PM, the Nursing Home Administrator (NHA) stated the facility had a new Infection Preventionist and Director of Nursing (DON). She stated they were so focused on orders and signage that adding the care plans were overlooked when asked if Resident #40's isolation precautions care plan was updated after he was diagnosed with COVID. The NHA also stated that the updated information should also be on Resident #40's Kardex.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that weights were obtained in accordance with physician orders for 3 of 5 residents (Resident #11, #23, and #55), reviewed for the provision of nursing services.Findings:Resident #11 (R11)Review of an admission Record revealed R11 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: edema.Review of R11's Order Summary dated 8/2/25 revealed, Monitor Weight WEEKLY every day shift every Mon for edema.Review of R11's Weight Summary summary revealed:11/4/2025 228.2 lbs11/10/2025 229.1 lbs11/17/2025 230.6 lbs12/8/2025 229.4 lbs1/5/2026 229.6 lbsReview of R11's November-January Medication Administration Record (MAR) revealed:No weight was obtained on 11/3/25 and the MAR was left blank.On 11/4/25 a weight of 228.2 lbs was documented in the Weight Summary.On 11/10/25 the weight of 228.2 lbs was documented in the MAR despite a weight of 229.1 lbs obtained on that date.On 11/17/2025 a weight of 230.6 lbs was obtained and documented in the MAR.On 11/24/25 no weight was obtained and the weight of 230.6 lbs was reused in the MAR.No weight was obtained on 12/1/25 and the MAR was left blank.On 12/8/25 the weight of 230.6 lbs (obtained on 11/17/25) was documented on the MAR despite a weight of 229.4 lbs obtained on that date.No weight was obtained on 12/15/25 and the MAR was left blank.On 12/22/25 the weight of 229.4 lbs (obtained on 12/8/25) was documented on the MAR.No weight was obtained on 12/29/25 and the MAR was left blank.Review of R11's Electronic Medical Record revealed no documentation that the resident refused to be weighed or a rationale for reusing/not obtaining weights as ordered.Resident #23 (R23)Review of an admission Record revealed R23 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: heart failure.Review of R23's Order Summary with a start date of 12/15/25 revealed, weights 3x weekly one time a day every Mon, Wed, Fri for chf (congestive heart failure).weight obtained on 12/17/25 was used for 12/19/25 and 12/22/25 Review of R23's Weight Summary revealed:12/17/2025 180.2 Lbs12/24/2025 176.4Review of R23's December Medication Administration Record (MAR) revealed:No weight was obtained on 12/19/25 and the weight obtained on 12/17/25 was documented on the MAR.No weight was obtained on 12/22/25 and the weight obtained on 12/17/25 was documented on the MAR.Review of R23's Electronic Medical Record revealed no documentation that the resident refused to be weighed or a rationale for reusing/not obtaining weights as ordered.Resident #55 (R55)Review of an admission Record revealed R55 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: heart failure.Review of R55's Order Summary dated 7/10/25 revealed, weights 2 x a week in the morning every Mon, Thu for edema.Review of R55's Weight Summary revealed:12/18/2025 297.6 lbs12/29/25 294.8 lbsReview of R55's Treatment Administration Record (TAR) revealed:On 12/18/25 a weight of 297.6 lbs was obtained.No weight was obtained on 12/22/25 and the weight obtained on 12/18/25 was documented on the TAR.No weight was obtained on 12/25/25 and the weight obtained on 12/18/25 was documented on the TAR.Review of R55's Electronic Medical Record revealed no documentation that the resident refused to be weighed or a rationale for reusing/not obtaining weights as ordered.During an interview on 01/07/2026 at 2:07 PM, the Director of Nursing (DON) confirmed that R11, R23, and R55's weights were not obtained following the providers order and the nurses were expected to obtain weights or document the rationale for not obtaining the weights.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Accuracy of weight measurement is important because health care providers base medical and nursing decisions (e.g., drug dosage, medications) on changes. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 558). Elsevier Health Sciences. Kindle Edition.

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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 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** Based on interview and record review, the facility failed to initiate bowel protocol for one of two resident's (Resident #43) reviewed for constipation. Findings:Resident #43 (R43) Review of an admission Record revealed R43 was an [AGE] year-old female who last admitted to the facility on [DATE], with pertinent diagnoses of dementia. During an interview on 01/05/26 at 12:19 PM, R43 reported constipation in the past month or so and could not recall if she had received any medications to help relieve the constipation. Review of Bowel and Bladder-Bowel Elimination Task Monitoring (a document that tracks when the resident has had a bowel movement) for R43 revealed R43 had a bowel movement on 12/10/25 in the afternoon. The next bowel movement was documented on 12/20/25 in the evening (10 days later). Review of an Electronic Medication Administration Record (Emar) for R43, dated December 2025, revealed the following order for medication to be given for constipation as needed: (1) Milk of Magnesium 2400 milligrams/30 milliliters, give 30 milliliters by mouth every 24 hours as needed for constipation, BM (bowel movement) protocol for no BM in 72 hours. R43 was not given this medication until the night of 12/19/25 (after 9 days of no bowel movement). During an interview on 01/07/26 at 11:32 AM, Regional Clinical Nurse (RCN) X stated that the facility does not have standing orders for bowel protocol, rather the nurses follow the PRN (as needed) orders in the Emar. Review of a Care Plan for R43 revealed a care plan specific to R43s risk for constipation and listed a goal of (R43) will have a normal bowel movement at least every 3 days. Interventions listed for staff to utilize to help R43 attain this goal included (a) administer medications as ordered, (b) follow facility bowel protocol for bowel management, and (c) monitor, document, and report signs and symptoms of complication related to constipation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement physician-approved pharmacy recommendations for 1 of 5 residents (R60) review for monthly medication regimen reviews. Findings include: A review of R60's admission Record, dated 1/8/26, revealed R60 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included dementia, post-traumatic stress disorder (PTSD), and chronic pain. A review of R60's Consultant Pharmacist Recommendation to Prescriber, dated 12/25/25, revealed the pharmacist noted that R60 had an order for Voltaren Gel (diclofenac sodium- a medication for knee pain). However, the pharmacist noted that there was not a specified quantity to be used for each dose and recommended that the physician write an order specifying the quantity (e.g., 4 grams) to be used with each dose with a maximum amount (e.g., 32 grams per joint per day) included per joint and per day. The physician agreed with the recommendation on 12/22/25. A review of R60's physician order, dated 12/22/25, revealed the physician ordered diclofenac sodium 1% gel to be applied to both knees topically (on the skin) four times a day for pain. However, a specified quantity and total amount per day was not included in the order. A review of R60's Medication Administration Record, dated 12/22/25 to 1/8/26, revealed R60 had received an unspecified amount of diclofenac sodium 1% gel with each dose and an unspecified total amount of diclofenac sodium gel per joint to both knees four times a day from 12/22/25 to 1/7/26 and one dose on 1/8/26 at 8:00 AM (the record was reviewed at on 1/8/26 1:34 PM before the 1:00 PM dose was administered). During an interview on 01/08/2026 at 1:50 PM, the Director of Nursing (DON) was notified that R60's diclofenac sodium (Voltaren) gel did not have an amount per dose and a total maximum amount to be administered per joint per day per R60's physician-approved pharmacy recommendation, dated 12/22/25. She stated she was aware that Voltaren gel should have an amount per dose listed with a maximum total amount to be administered per joint per day. The DON stated she knew that the maximum amount that could be administered per joint per day for knee joints was 16 grams per joint per day for a total maximum of 32 grams for both knees combined. She stated she knew this because she had processed a lot of Voltaren orders in the past. A review of the manufacturer's instructions for Voltaren Gel (diclofenac sodium) 1% revealed for each lower body area (foot, ankle, or knee) 4 grams of gel (4.5 inches) should be applied four times a day. In addition, the manufacturer's instructions revealed that side effects of diclofenac sodium gel included stomach bleeding (higher risk in adults 60 years and older), heart attack and stroke (risk is higher if more than the recommended amount is used), hives, wheezing, facial swelling, shock, and liver failure (if more than the recommended dose is given) (retrieved on 1/12/26 from https://www.voltarengel.com).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately monitor vital signs and ensure medications were administered in accordance with physician orders for 2 residents (Residents #6 and #10) out of 18 residents reviewed for unnecessary medication.Findings:Resident #6 (R6)Review of an admission Record revealed R6 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and heart failure.Review of R6's Order Summary dated 7/29/25 revealed, Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet via G-Tube three times a day for dialysis patient Do not give too early, just before leaving for HD (hemodialysis)/hold for SBP >120 (systolic blood pressure [top number] greater than 120). To be administered at 9:00 AM, 1:00 PM, and 9:00 PM.Review of R6's Blood Pressure Summary and January Medication Administration Record revealed:On 1/1/26 R6's blood pressure was last assessed at 1:11 PM. No blood pressure was assessed prior to the 9:00 PM dose and the midodrine was administered.On 1/2/26 R6's blood pressure was last assessed at 1:05 AM. No blood pressure was assessed prior to the 9:00 AM dose and the midodrine was administered.On 1/3/26 R6's blood pressure was assessed only one time at 6:30 PM. No blood pressures were assessed prior to the 9:00 AM and 1:00 PM doses and the midodrine was administered.On 1/4/26 R6's blood pressure was assessed at 4:31 AM. No blood pressures were assessed prior to the 9:00 AM and 1:00 PM doses and the midodrine was administered.On 1/4/26 at 6:10 PM R6's blood pressure was 129/42 at the 9:00 PM dose was administered (out of parameters).Resident #10 (R10)Review of an admission Record revealed R10 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertensionReview of R10's Order Summary dated 9/25/25 revealed, Lasix Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth two times a day for edema hold for sbp<110 (systolic blood pressure less than 110). To be administered at 8:00 AM and 2:00 PM.Review of R10's Blood Pressure Summary and December-January Medication Administration Record (MAR) revealed:On 12/9/25 R10's blood pressure was 137/72 at 8:26 AM. A blood pressure was not assessed prior to the 2:00 PM dose. The morning blood pressure result was documented on the MAR and R10's Lasix was administered.On 12/14/25 R10's blood pressure 147/61 at 12:17 AM. A blood pressure was not assessed prior to the 8:00 AM and 2:00 PM doses. The 12:17 AM blood pressure was documented on the MAR for both doses, and R10's Lasix was administered.On 12/21/25 R10's blood pressure was documented as 110/36 at 10:04 AM, 11:29 AM, and 2:24 PM. The 8:00 AM and 2:00 PM doses of Lasix were held for Vitals outside of parameters for administration despite the SBP not being less than 110.On 12/25/25 R10's blood pressure was documented as 118/51 at 11:10 AM and 2:12 PM. The 8:00 AM dose was documented as administered. The 2:00 PM dose was held for Vitals outside of parameters for administration despite the SBP being greater than 110.On 12/28/25 R10's blood pressure was 129/55 at 8:05 AM. A blood pressure was not assessed prior to the 2:00 PM dose. The 8:05 AM blood pressure was documented on the MAR, and R10's Lasix was administered.On 1/1/26 R10's blood pressure was 115/57 at 8:08 AM. A blood pressure was not assessed prior to the 2:00 PM dose. The 8:08 AM blood pressure was documented on the MAR, and R10's Lasix was administered.During an interview on 01/07/2026 at 2:07 PM, the Director of Nursing (DON) confirmed that R6 and R10's vital signs were not obtained prior to each administration of the medications following the providers' orders. The DON reported that the expectation was for the licensed nurses to follow the ordered parameters and obtain vital signs prior to the administration of medications.Review of the facility policy Medication Administration issued 8/7/23 revealed, .Vital Signs are taken prior to the administration of vital sign dependent medications in accordance with medical practitioner's orders.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Use vital sign measurements to determine indications for medication administration. For example, give certain cardiac drugs only within a range of pulse or BP values.Know the acceptable vital sign ranges for your (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patients before administering medications. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book. Elsevier. Kindle Edition.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure laboratory tests were completed and laboratory results were obtained for 3 of 18 residents (Resident #81, #101 and #10) reviewed for laboratory services.Findings:Resident #81 (R81) Review of an admission Record revealed R81 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and presence of cardiac pacemaker. Review of R81's Order Summary dated 12/13/25 revealed: Coumadin (Warfarin Sodium) Give 5 mg by mouth one time a day every Mon, Wed, Thu, Fri, Sun for anticoagulation ENSURE COUMADIN FLOWSHEET IS ACTIVE IN ASSESSMENTS AND Coumadin Tablet (Warfarin Sodium) Give 2.5 mg by mouth one time a day every Tue, Sat for anticoagulation ENSURE COUMADIN FLOWSHEET IS ACTIVE IN ASSESSMENTS Review of R81's Electronic Medical Record revealed no Coumadin Flowsheet (used to track, trend, and monitor PT/INR [bloodwork] results for medication management.) Review of R81's Care Plan revealed no anticoagulant monitoring or PT/INR schedule. Review of R81's Order Summary dated 12/14/25 revealed, PT and INR one time only for use of coumadin until 12/15/2025 call results to Dr. Review of R81's Pharmacy Recommendation dated 12/16/25 revealed, Pt (patient) is on Warfarin (coumadin) and has a one time order for PT and INR for 12/15/25. Please address with prescriber for routine PT/INR monitoring and update accordingly. A handwritten note initialed by provider and dated 12/17/15 revealed, PTINR in am. Review of R81's Order Summary dated 12/17/25 revealed, Obtain PT/INR result one time only for coumadin for 1 Day Review of R81's Order Summary dated 12/19/25 revealed, PT/INR (indicating a PT/INR was to be drawn). Review of the Provider Communication book (located at the nurses' station) revealed an entry dated 12/20/25 (R81) Has no orders for PT/INR checks, is on coumadin. (1 week after admission to the facility). The entry had a pen line though it which indicated that it had been reviewed. Review of R81's Order Summary dated 12/23/25 revealed, PT/INR Review of R81's Order Summary dated 12/28/25 revealed, PT/INR next lab day one time only for coumadin monitoring until 12/30/2025 Review of R81's Order Summary dated 12/30/25 revealed, Cefuroxime Axetil Oral Tablet 250 MG (cephalosporin antibiotic) Give 1 tablet by mouth one time a day for Acute Cystitis for 7 Days. (Cephalosporins can potentiate the anticoagulant effects of coumadin). There was no documentation that increased monitoring of R81's PT/INR was completed/considered. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R81's Electronic Medication Administration Record-Administration Note dated 12/31/2025 revealed, (provider) notified that pt/inr has not been drawn, will attempt to have drawn at next dialysis date. Review of R81's Order Summary dated 12/31/25 revealed, PT/INR at dialysis on 1-2-26 Review of R81's Hemodialysis Communication Form dated 1/2/26 revealed a handwritten note We (dialysis facility) do not draw this lab (PT/INR). Review of R81's Electronic Medication Administration Record-Administration Note dated 1/2/26 revealed, .spoke with (facility provider), give med without PTIR, order stat (immediate) labs. Review of R81's Electronic Medication Administration Record-Administration Note dated 1/5/2026 revealed, .Drs ordered to give Coumadin per order lab will be drawn in the am, drs and management notified. On 1/6/26 at 1:56 PM a request for R81's PT/INR log was sent via email to the Nursing Home Administrator (NHA). On 1/6/26 at 3:38 PM and 3:48 PM a printout of R81's bloodwork was provided with results from 12/20/25 and 12/30/25 (obtained while in the Emergency Department on 2 separate occasions). There were no PT/INR results from 12/15/25, 12/17/25, 12/23/25, or 1/2/26 available. During an interview on 01/07/2026 at 2:07 PM, the Director of Nursing (DON) confirmed that the Coumadin Flowsheet and PT/INRs (excluding the PT/INRs obtained at the hospital on [DATE] and 12/30/25) for R81 were not available/completed. During an interview on 01/08/2026 at 12:55 PM, the DON was asked if R81's PT/INR was drawn on 1/6/26. The DON provided a copy of the result which had been collected on 1/6/26 and resulted on 1/7/26 at 10:17 AM. The DON reported that the provider had not yet reviewed the results.(Indicating the stat labs ordered on 1/2/26 had not been completed/reviewed for approximately 6 days.) Resident #101 (R101) Review of an admission Record revealed R101 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: atrial fibrillation (abnormal beating of the heart). Review of R101's Electronic Medical Record revealed no Coumadin Flowsheet. Review of R101's Care Plan revealed no anticoagulant monitoring or PT/INR schedule. Review of R101's hospital Discharge Notes generated on 12/23/25 revealed, .(discharged) on home warfarin (coumadin) scheduling with plan to check INR 3x (3 times) weekly. Review of the Provider Communication book with an entry dated 12/23/25 revealed, (R101) on coumadin ? next INR. The entry had a pen line though it which indicated that it had been reviewed. Review of R101's physician History and Physical dated 12/24/25 revealed, .on coumadin 10mg thur, 7.5mg all other days; last inr 2.3 on 12/23; to have next inr 12/26. Review of R101's Nursing admission Note dated 12/23/25 revealed, .resident receives coumadin, INR (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	today 2.4, PA made aware of, ordered lab to draw INR and PTT 12/26/25. Review of R101's Order Summary dated 12/23/25 revealed, INR 12-26-25, call results to MD for coumadin orders one time only for coumadin management until 12/26/2025. Review of R101's Electronic Health Record revealed no documentation for the rationale for not obtaining the PT/INR on 12/26/25. On 1/6/26 1:56 PM a request for R101's Coumadin Flowsheet was requested via email to the NHA. On 01/06/26 at 3:38 PM the NHA provided only a PT/INR result from 12/30/25 (indicating there was no Coumadin Flowsheet). During an interview on 01/08/2026 at 11:16 AM, the DON confirmed R101 did not have a PT/INR drawn on 12/26/25 which was resulted and reviewed by the provider after his discharge from the facility. (R101 discharged from the facility on 1/2/26) and the PT/INR was reviewed by the provider on 1/5/26. Review of R101's Laboratory Result revealed a collection date of 12/30/25 and a result date of 12/30/25. A handwritten note by the provider was dated on 1/5/26 (indicating the lab had not been reviewed until that date) with a note Pt d/c'd (discharged) now. During an interview on 01/08/2026 at 12:55 PM, the DON reported that the facility had been having ongoing issues with the contracted laboratory company obtaining lab specimens timely and resulting the lab specimens timely. During an interview on 1/7/25 at 8:37 AM, Registered Nurse (RN) JJ reported that the Coumadin Flowsheets were found under the Assessments tab in the Electronic Medical Record. Review of the facility policy Medication Administration issued 8/7/23 revealed, .Laboratory values are validated prior to the administration of laboratory dependent medications in accordance with medical practitioner's orders. During an interview via email on 01/07/2026 at 12:57 PM, NHA reported that there were no coumadin specific policies and Standard of practice is followed in orders individualized by each patient. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, (Nurses) are also responsible for documenting any preassessment data required with certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book. Elsevier. Kindle Edition. Resident #10 (R10) Review of an admission Record revealed R10 was an [AGE] year-old female. Review of a physician order form for R10 reflected the lab order for a lipid panel, dated 12/22/25. During an interview on 01/08/26 at 12:44 PM, Nurse Practitioner (NP) W reviewed R10's Electronic Health Record (EHR) and indicated that the lipid panel ordered 12/22/25 had not been completed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to Intake 2643393. Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 of 18 sampled residents (R74). Findings include: A review of R74's admission Record, dated 1/7/26, revealed R74 was an [AGE] year-old that was admitted to the facility on [DATE]. In addition, R74's admission Record revealed multiple diagnoses that included dementia with agitation and psychotic disturbance, anxiety, and bipolar disorder. A review of R74's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 11/22/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R74 was cognitively intact. A review of the facility's investigation report, dated 9/30/25, revealed on 9/23/25 at 11:00 AM, the Nursing Home Administrator (NHA) was notified by a nurse aide that R74 alleged he was yelled at by Certified Nursing Assistant (CNA) G a few days ago and it was upsetting to him. The NHA went to speak to R74, but he could not recall the name of the aide that yelled at him but did state that he was upset because he felt he was yelled at when he was just trying to tell the aide that his roommate's urinal should not be in the bathroom. During an interview on 1/5/26 at 1:00 PM R74 stated he has had some issues with staff. He stated he has only had an altercation with one aide and it was just a verbal altercation. R74 stated the staff member touched his things and he yelled at her. He stated he told her to get the h*** out of my room. R74 did not remember the aide's name that he had a verbal altercation with and he did not remember any other incidents besides that one. A review of R74's typed interview statement, dated 9/26/25, revealed R74 stated he told the aide that the urinals do not belong in his bathroom. He stated the aide spoke to him in a way he did not like. R74 stated he did not remember the aide's name. He also stated he was not scared and felt safe in the facility. A review of CNA H's typed and signed statement, dated 9/23/25, revealed R74 called her over and told her about the interaction he had with an aide a few days before. She stated he told her that he was arguing with CNA G about the urinal being left in the bathroom, that he had removed it from the bathroom, and that he threw it on the floor. He told her that CNA G was screaming at him and that RN F intervened. CNA H stated that R74 seemed fearful when he stated that he would protect himself from her if he had to. CNA H stated she immediately reported this incident to the facility abuse coordinator. A review of R74's electronic medical record, dated 9/8/25 to 10/6/25, failed to reveal any mention of an incident between R74 and staff on, or around, 9/23/25 and/or any follow-up visits after a possible incident (e.g., social service visits evaluating R74's psychosocial well-being). In fact, R74's electronic medical record failed to reveal any incidents during this time where R74 was yelling/verbally aggressive towards staff and/or staff were yelling/verbally aggressive towards him. During an interview on 01/07/2026 at 2:15 PM, the Director of Nursing (DON) stated she would expect that if a resident complained that a staff member yelled at them then the nurse would write a progress note. She then said she was not sure if the nurse would document if a resident made an accusation that a staff member yelled at them or swore at them in a progress note or where it would be documented, if at all. She further stated staff would definitely document if a resident yelled at staff or if they swore at staff. The DON finally stated she would have to ask the NHA if staff would document an accusation in the resident's medical record that staff yell or swore at them and where it would be documented. During a second interview on 01/07/2026 at 2:25 PM, the DON stated she spoke with the NHA. She stated the NHA told her that if a resident accused staff of yelling at them or swearing at them, then it would be documented in [name of the system the facility uses to report incidents to the State Survey Agency] and in a risk management form. She stated the NHA said all the documents go there. The DON further stated that the accusation would not be documented in the resident's medical record. She also stated that she did not think that staff would document that they notified the NHA/facility abuse (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Wyoming	625 36th Street SW Wyoming, MI 49509

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coordinator in the resident's medical record. She stated that it would all be in the investigative file (an internal file that was not a part of a resident's medical record) During an interview on 01/07/2026 at 2:50 PM, the NHA stated when she gets an allegation (e.g., a staff member yells at a resident) she puts the information in [name of the system the facility uses to report incidents to the State Survey Agency]. She stated she also starts a risk management form for the incident and the information is put in there. She further stated the risk management form is a facility internal document and is not a part of the resident's medical record. The NHA also stated they do not document the information for an allegation that staff yelled or swore at a resident (an allegation of abuse) in the resident's medical record. She stated even though they do not document the resident's initial accusation in their medical record, the social worker will do follow-up visits related to the allegation to ensure the resident feels safe at the facility and does not have any negative outcomes from the allegation. The NHA stated the social worker's follow-up visits should be documented in the resident's medical record. She also stated that R74 yells at staff frequently and that should be documented in R74's medical record. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care- Assessments; Clinical problems; Communications with other health care professionals regarding the patient; Communication with and education of the patient, family, and the patient's designated support person and other third parties. Patient responses and outcomes, including changes in the patient's status . Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 7/27/25).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the antibiotic stewardship program for 2 of 7 residents (Resident #25 and #81) reviewed for antibiotic use.Findings:Resident #25 (R25)Review of an admission Record revealed R52 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: acute kidney failure.Review of a provider Progress Note dated 12/15/25 revealed, Patient is seen for cloudy malodorous urine, she denies dysuria (pain/discomfort with urination), urine is in bed pan in bathroom for me to visualize. meds rev (medications reviewed) vss (vital signs stable). Patient w/o (without) fever or chills.Plan: will check UA (urinalysis) with c/s (culture and sensitivity) if indicated, malodorous urine, cloudy in nature, patient mildly lethargic this am per staff, not at her baseline. No other diagnostic studies were ordered (bloodwork).Review of R25's Electronic Medical Record revealed no documented symptoms of a UTI outside of the provider's note prior to 12/15/25.Review of R25's Laboratory Results revealed R25's urine was collected on 12/17/25 and received on 12/18/25. On 12/23/25 the culture and sensitivity report resulted.Review of R25's Nursing Progress Note dated 12/23/2025 revealed, labs came back indicating a UTI PA (physician assistant) notifiedReview of R25's Urine Culture revealed the sensitivity report resulted on 12/23/25 and reviewed by the provider (initialed and dated) on 12/24/25.Review of R25's Order Summary dated 12/25/25 revealed, Nitrofurantoin Macrocrystal Oral Capsule 100 MG (Macrobid/antibiotic) Give 100 mg by mouth two times a day for UTI for 7 Days. To be administered at 9:00 AM and 9:00 PM.Review of R25's Electronic Medical Record revealed no documented symptoms of a UTI from 12/15/25 through the start of the antibiotic on 12/25/25 (10 days).Review of R25's Infection Control Worksheet revealed a symptom onset date of 12/15/25. It was documented that McGeer Criteria was met (used to determine the presence of an infection) despite the lack of clinical symptoms documented. Review of the Constitutional Criteria revealed no criteria was documented to indicate the resident was experiencing clinical symptoms of a UTI and therefore the McGeer Criteria could not be met.Review of the Provider Communication book located at the nurses' station revealed an entry for R25 dated 12/26/25 missed does (sic-doses) of ABX (antibiotics).Review of R25's Medication Administration Record revealed the first dose of Macrobid was to be on 12/25/25. A dose of Macrobid was not administered on 12/25/25 at 9:00 AM, on 12/25/25 at 9:00 PM, or on 12/26/25 at 9:00 AM. Indicating the antibiotic was not administered in its entirety/as ordered (11 out 14 doses received).Review of R25's Electronic Medication Administration Record-Administration Notes revealed:On 12/25/2025 the morning dose was not administered because it was on order.On 12/25/2025 the evening dose was not administered due to medication on order.On 12/26/2025 the morning dose was not administered due to it was on order.Review of the automated medication dispensing system printout revealed there was no Macrobid pulled from the stock on 12/25/25 and 12/26/25.Resident #81 (R81)Review of an admission Record revealed R81 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: end stage renal disease.Review of R81's Nursing Progress Note dated 12/30/2025 revealed, Resident picked up from facility via ambulance, transferring to (name omitted) hospital for workup and labs to be done.Review of R81's Electronic Medical Record revealed no documented symptoms of a UTI prior to his transfer to the hospital.Review of R81's Nursing Progress Note dated 12/3025 revealed, Resident returned from (hospital via ambulance); Diagnoses: Acute Cystitis without hematuria. Resident return with RX (prescription) for Cefuroxime 250 mg 1 tab daily for 7 days.Review of R81's provider Progress Note dated 1/6/26 revealed, Continue Ceftin 250 mg 1 p.o. (by mouth) daily through January 7, 2026.He was seen in the ER, (emergency room) antibiotic ordered from the ER. Will request urine culture done in the emergency room. They have not sent this from the hospital. Will ensure patient is on correct antibiotic. He is without fever or chills. He is denying urinary complaints today. (Approximately 6 days following his discharge from the hospital emergency (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room).Review of R81's Urine Culture resulted on 1/1/26 revealed no growth of bacteria with only resident flora detected. (Indicating no infection.)Review of R81's Infection Control Worksheet revealed a symptom onset date of 12/30/25. It was documented that McGeer Criteria was met despite the lack of clinical symptoms documented. Review of the Constitutional Criteria revealed no criteria was documented to indicate the resident was experiencing clinical symptoms of a UTI and therefore the McGeer Criteria could not be met.On 1/8/26 at 10:33 AM a request for supporting documentation for R81's UTI symptoms was requested via email to the Nursing Home Administrator (NHA). No documentation was received prior to survey exit.Review of R81's Order Summary dated 12/30/25 revealed, Cefuroxime Axetil Oral Tablet 250 MG (antibiotic) Give 1 tablet by mouth one time a day for Acute Cystitis for 7 Days.Review of R81's Medication Administration Record revealed the first dose of cefuroxime was to be on 12/31/25. A dose of cefuroxime was not administered on 1/4/26 or 1/5/26. Indicating the antibiotic was not administered in its entirety/as ordered (5 out 7 doses received).Review of R81's Electronic Medication Administration Record-Administration Notes revealed:On 1/4/26 the dose was not administered due to oos (out of stock).On 1/5/26 the dose was not administered due to waiting on pharmacy.On 1/6/26 the dose was not administered due to waiting on pharmacy, not in (automated medication dispenser).Review of the automated medication dispensing system printout revealed there was no cefuroxime pulled from the stock on 1/3/26, 1/4/26, or 1/5/26.During an interview on 01/08/2026 at 9:06 AM, Infection Control Preventionist (ICP) Z and the Director of Nursing (DON) reported that when a resident returns from the hospital with a diagnosis of a UTI, the ICP is responsible for following up with the laboratory and ensuring a culture of the urine was obtained and ensure that the bacteria is susceptible to the antibiotic (ensure a culture and sensitivity is ordered and acted upon).ICP Z reported that the facility providers always want a culture prior to starting antibiotics to ensure the correct antibiotic is prescribed.During an interview on 01/08/2026 at 11:16 AM, the DON reported that antibiotics are available in the medication room in the automated medication dispensing system for new orders that need to be started prior to the pharmacy dropping off the medication.During an interview on 01/08/2026 at 12:55 PM, the DON and Regional Clinical Nurse (RCN) X reviewed R25 and R81's antibiotics (Macrobid and cefuroxime) and confirmed those medications were available in the facility's automated medication dispensing system and the R25 and R81 should not have missed doses.Review of the facility policy Antibiotic Stewardship last revised 9/25/24 revealed, .Facility staff and medical practitioners have a responsibility to assure that antibiotics are requested and provided only when the root cause is determined to be a bacterial infection and only for the length of time needed to adequately treat the infection. The facility follows the CDC's core elements for antibiotic stewardship which includes: Leadership commitment/ including the Director of Nursing/ Infection Preventionist, Medical Director, and Consultant Pharmacist/ to the safe and appropriate use of antibiotics by ensuring that: Antibiotic stewardship prescribing protocols are followed: Utilization of McGeer's criteria in determining the presence of symptoms meets the definition of an infection. Diagnostic testing required to be completed per McGeer's criteria prior to initiation of antibiotic orders. Tracking is demonstrated by: Monitoring various measures of antibiotic use/ which may include:Adherence to clinical evaluation documentation including signs, symptoms, and other physical examination findings in the resident's electronic medical record.Adherence to cultures obtained before antibiotics are initiated or changed after culture results are received. o Adherence to completeness of orders with name/ dose/ route/ frequency, duration, and indication. Diagnostic test results received that do not meet criteria will be reported to the medical practitioner for further evaluation of need.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, UTIs are characterized by location (i.e., upper urinary tract [kidney] or lower urinary tract [bladder, urethra]) and have signs and symptoms of infection. Bacteriuria, or bacteria in the urine, does not always mean that there is a UTI. In the absence of symptoms, the presence of bacteria in the urine as found on a urine culture is called asymptomatic bacteriuria and is not considered an infection and should not be treated with antibiotics ([NAME], (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2019). Symptomatic infection of the bladder can lead to a serious upper UTI (pyelonephritis) and life-threatening bloodstream infection (bacteremia or urosepsis) and should be treated with antibiotics. Symptoms of a lower UTI (bladder) can include burning or pain with urination (dysuria); irritation of the bladder (cystitis) characterized by urgency, frequency, incontinence, or suprapubic tenderness; and foul-smelling cloudy urine. Older adults who develop infections, including UTIs, often have nonspecific symptoms such as delirium, confusion, fatigue, loss of appetite, decline in function, mental status changes, incontinence, falls, or subnormal temperature (Touhy and [NAME], 2020). [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1229). Elsevier Health Sciences. Kindle Edition.