STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235442	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Lakes Rehabilitation Center	4180 Tittabawassee Road Saginaw, MI 48604

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement meaningful interventions to prevent pressure ulcers for one resident (R30) and complete consistent wound documentation for one resident (R29) of two residents reviewed for pressure ulcers, resulting in the development of an unstageable pressure ulcer and inconsistent wound documentation. Findings include: Resident #29: On 1/13/2026 at 11:40 AM, an interview was conducted with Wound Nurse G regarding Resident #29's wound she admitted with. The nurse reported the resident was admitted from home with a Stage 2 coccyx wound and they are now monitoring the area. She explained the resident prefers being in her chair most of the day and refuses staff attempts to reposition her. Wound Nurse G was queried on the current interventions in place to prevent development of wounds and she stated she has a low air loss mattress. On 1/13/2026 at 12:00 PM, an interview was conducted with MDS (Minimum Data Set) Coordinator R, regarding Resident #29's wound. She stated the resident admitted with a pressure ulcer and it resolved and reopened in November 2025. Review was conducted of Resident #29's record and it revealed she admitted to the facility on [DATE] with diagnoses that included, Progressive Multiple Sclerosis, Bacteremia, Hyperlipidemia, Peripheral Vascular Disease and Quadriplegia. Further review was completed and it showed the following: Progress Notes: 6/30/2025 at 10:50: Resident was receiving bed bath when approached for wound treatment, denies pain, and is agreeable. Wound bed is 0.5cm x 1.0 with kerotic edges. Peri wound is red and blanchable. Will continue current treatment until assessed by NP (Nurse Practitioner) . Care Plan: (Resident #29) has an increased risk for skin impairment r/t (related to).known skin impairment – P2 sacrum, present on admit, 5/21/25 deterioration noted 9/11/25.air mattress applied to bed.monitor/document location, size and treatment of skin injury, report abnormalities. There were minimal interventions listed for prevention of skin alterations and there was nothing located regarding refusals to adhere to facility implemented interventions. 8/8/2025 at 12:03: Resident admitted from home on 5-21-25 with healing stage II pressure injury to (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	coccyx/sacrum. Residents healing has been monitored and continues to improve. Currently, previously scabbed area has superficial skin loss and red. Measures approximately 1.0cm x 0.5cm with superficial skin loss. will continue current treatment until assessed by NP. Review was completed of Resident #29's Skin & Wound evaluation notes, it was found there was no consistent monitoring and assessment to include pictures, measurements, staging, further interventions, changes of treatment orders (if applicable) and description of wound. Skin & Wound Evaluations were completed on the following days: 5/21/25- Admission 6/3/25- readmission to facility 11/5/25 11/19/25 On 01/13/2026 at 1:14 PM, an interview was conducted with Wound Nurse G. She reported Resident #29 has a standard cushion in her chair and it would not be listed on her careplan or in an order. She expressed there is an order in the MAR (Medication Administration Record) for refusals to offload. The order stated, Encourage resident to lay down and offload throughout the day. Document refusals in nursing note. Nurse G was asked for clarity regarding the order as it was unclear how to interpret the responses indicated by nursing staff. Nurse G reported she would review the order and return with an answer. Upon her returning it was explained if the MAR indicated a No or N meant that the resident refused to lay down when approached by staff. Nurse G reported Resident #29 does not currently have a pressure ulcer and she assesses her skin monthly. She was further asked why the resident had two [NAME] orders, the orders are as follows: Cleanse sacral breakdown with Ph balances cleanser, dry, [NAME] thin layer of [NAME] every shift for breakdown. Entered on 11/17/2025 by Wound Nurse G Apply [NAME] to b/l (bilateral) buttock and sacrum- every shift for breakdown prevention and as needed for missing or soiled dressing. Order was entered on 8/25/205 by Wound Nurse G. Wound Nurse G reported she was not aware the resident had two orders for [NAME] (one for breakdown and the other for prevention) even though she was the nurse that entered both orders. On 1/14/2026 at 3:30 PM, Wound Nurse G explained Resident #29 should only have one order for [NAME]. One order was for breakdown and the other for prevention. Nurse G shared on 11/7/2025 the resident began to have maceration that was discovered during a skin assessment which is where the November 2025 [NAME] ordered originated from. Nurse G was asked to provide Resident #29's weekly wound notes from admission to when the wound first resolved and notes when it reopened. The nurse returned and expressed Resident #29 admitted with the wound and it resolved on 7/7/2025 and reopened on 8/8/2025. Nurse G provided a handwritten document with the following information: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/21/25- admitted with 5/27/25- Hospital 6/3/25- readmitted with excoriation Nurse G off work from 6/13/25 to 6/15/25 6/30/25- Nurses note regarding wound 7/7/25- skin assessment showing wound closed Worked floor 6/2/25, 6/3/25, 6/4/25 and 6/23/25. Wound Nurse G stated she did not have weekly wound assessments of Resident #29's wound from admission to when it closed on 7/7/2025 because she was working the floor and not able to perform her job function as a wound nurse. Resident #29's coccyx wound was not being consistently monitored. Resident #30 R30 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hypertension, fractures with routine healing, falls and chronic kidney disease. R30 was deemed capable of making her own decisions. On 01/12/2026 at 10:05AM, R30 was observed sitting in her wheelchair with a dressing on her left foot. R30 stated that someone was supposed to come down and change the dressing, but no one has done it yet. On 01/12/26 at 10:25AM, record review revealed that R30 developed a pressure ulcer on her left heel on 12/29/25 and it was facility acquired. On 01/14/2026 at 11:31AM, R30 was observed in her wheelchair. Licensed Practical Nurse (LPN) F was observed completing wound care on the left heel. LPN F was asked if R30 wears her protective PRAFO boot, LPN F stated that R30 refuses to wear her PRAFO boot quite often. This surveyor observed the pressure injury on the heel. LPN F was asked how the wound started. LPN F stated the left heel injury started as a blister and opened. LPN F offered R30 the PRAFO boot for her left heel R30 accepted and the boot was placed for protection. On 01/14/2026 at 11:47AM, an interview was conducted with wound care G. Wound care G was asked if the pressure ulcer on the left heel was present on admission. Wound care G stated, no, but the heels were boggy (soft, spongy feeling) on admission and R30 does not like to wear her PRAFO boot, and she lays in bed a lot. Wound care G stated one of the nurses did the skin assessment and they noted it as a skin tear and not a blister. When I looked at it, I spoke with the Nurse Practitioner (NP), we put the heel cup in place and R30 was still not elevating her feet. The NP saw her again, trimmed extra skin off the blister, the weekend went by and R30 was still not elevating her feet and the heel worsened. Wound care G was asked when the PRAFO boot was put in place for protection. Wound care G stated, we started the PRAFO boot on Monday 1/12/26. Wound care G was asked if R30 is in bed does staff elevate her heels. Wound care G stated, the staff try but she will refuse. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 01/14/2026 at 12:13PM, record review of care plans for R30 revealed a care plan for skin impairment in place. Focus R30 has an increased risk for skin impairment, initiated 12/23/25 and R30 has a known skin impairment Unstageable pressure wound, left heel, initiated 12/29/25 Interventions included: -Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Initiated 12/23/25 -Encourage good nutrition and hydration in order to promote healthier skin. Initiated 12/23/25. -Identify/document potential causative factors and eliminate/resolve where possible. Initiated 12/23/25 -Prafo boot to left heel at all times as tolerated. Initiated 01/12/26 -Use a draw sheet or lifting device to move resident. Initiated 12/23/25 -Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Initiated 12/23/25 The care plan for skin impairment does not have additional interventions for pressure prevention other than a PRAFO boot that was put in place on 1/12/26. On 01/14/2026 at 12:27PM, record review of the admission assessment and skin assessment revealed that R30's heels were boggy on admission. On 01/14/2026 at 12:36PM, record review of the Braden Scale for Predicting Pressure Sore, revealed a risk score of 14, indicating moderate risk for pressure ulcer. On 01/14/2026 at 1:45PM, an interview was conducted with the Director of Nursing (DON). The DON was asked where interventions for wound prevention would be in the electronic medical record. The DON stated, I would like to see the interventions be in the tasks, that way the aides can see them, ensure they are getting put in place and document that it was completed. On 01/14/2026 1:58PM, an interview was conducted with wound care G. Wound care G was asked if there should there have been more interventions for pressure ulcer prevention in place prior to the blister forming since R30's heel were already boggy. Wound care G stated there should have been skin prep (a product that protects the skin against irritation and damage caused by tapes, films and bodily fluids) in place and the standard of care is to elevate the heels. We do bi-weekly skin assessments as well. Wound care G was asked if they would care plan elevating the heels of a resident. Wound care G again stated, the standard of care is to elevate the heels off the bed, and we wouldn't put that in a care plan since it's a standard of care. Wound care G was asked if they thought the staff was elevating her heels or doing what they could to prevent the development of the pressure injury on the left heel. Wound care G stated, I feel like R30 does what she wants and she was not excited about the interventions we put in place. Wound care G was asked if they should have put the PRAFO boot(s) on prior to development of the pressure ulcer as an intervention to prevent breakdown. Wound care G stated, it would have been a good intervention to have in place, but it is not typically something we do on admission. If they would have had the PRAFO boots in the hospital, then I would've put them in (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	place. Otherwise, we don't keep many of the PRAFO boots on hand, we happened to have one here so we could put it on her. On 01/14/2026 at 2:22PM, Certified Nursing Assistant (CNA) H was interviewed. CNA H was asked, If you are supposed to elevate a residents' heels where would you find that in the Electronic Medical Record (EMR). CNA H stated, I would find it in the EMR in the Kardex (which comes from the care plans) and in the room on a piece of paper in the closet. CNA H stated they are the staff member that prints out the Kardex from the EMR and places it in each resident's room on a weekly basis or as needed with a change. CNA H stated they highlight important interventions for the residents such as items for pressure prevention or the amount of assistance needed to transfer, as examples. Verified with CNA H that the Kardex did not indicate to elevate heels for R30. On 01/14/2026 at 3:41PM, an interview was conducted with LPN I. LPN I was asked what skin prep is. LPN I stated that it was a wipe they use on the skin of residents for putting on dressings. LPN I was asked if they needed a physician's order to use this product. LPN I stated, yes, there is typically an order in place to use the prep. LPN I was asked who can apply the skin prep. LPN I stated that nurses can apply it. On 01/14/26 at 3:55PM, record review of physician orders revealed that there was no order for skin prep. Record review also revealed no documentation for elevating the heels of R30. Review of the policy titled, Wound Management Program, revealed, Policy: To assure that residents who are admitted with, or acquire wounds receive treatment and services to promote healing, prevent complications and prevent new skin conditions from developing. Process (prevention): 3. Place initial interventions for residents at risk for development of skin breakdown in care plan.

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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. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents who consume food from the kitchen.Findings include: On 01/12/2026 at 9:20am-9:40am during the initial kitchen tour with Certified Dietary Manager C observed chicken noodle soup inside refrigerator without datemarking. During this observation, CDM C was asked when the chicken noodle soup was prepared and stated she wasn't sure and removed the chicken noodle soup from the fridge. On 01/12/2026 at 9:20am-9:40am observed the mixer visibly soiled with a yellow residue. During this observation CDM C was asked how often the mixer is cleaned and stated it's cleaned after each use. On 01/12/2026 at 9:20am-9:40am observed the microwave visibly soiled on the interior ceiling. During this observation CDM C was asked how often the microwave is cleaned and stated it's cleaned after each meal. On 01/12/2026 at 9:20am-9:40am observed a chunky yellow residue on the interior walls of the ice machine. During this observation CDM C was asked how often the ice machine is cleaned and stated that maintenance is supposed to clean it monthly. On 01/12/2026 at noon-12:50pm during lunch observation observed [NAME] D put on gloves without washing hands and proceeded to prepare food in the kitchen. On 01/12/2026 at noon-12:50pm observed [NAME] D remove gloves and put new gloves on without washing hands and continued to prepare lunch in the kitchen. On 01/12/2026 at noon-12:50pm during interview with CDM C on handwashing procedures when using gloves, CDM C stated that hands should be washed after taking off gloves.According to the 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms.immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and.Before donning gloves to initiate a task that involves working with food.On 01/12/2026 at 1:12pm-1:30pm during interview with Maintenance E on the cleaning schedule for the ice machine, he stated that the ice machines are cleaned once a month, but there isn't a cleaning log for the ice machine. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the facility's policy on sanitization, All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. Equipment used daily, ie microwave, stove, etc. is to be cleaned daily at end of shift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement an ongoing infection prevention and control program, resulting in a lack of precautions for one resident (Resident #61) with an eye infection and the absence of line listings, infection control audits and surveillance for multiple months. Findings include: On 01/13/2026 at 11:43 AM An interview was conducted with the Infection Control (IC) nurse B to set up a time to go over the infection control program. IC nurse B stated that she was behind on infection control tasks, she stated that she had some of the line listings for January 2026 completed, some of December 2025 completed and currently she is working on August 2025. IC nurse B stated that there is no line listing completed for September, October, November and part of December 2025. A time was set up for 1:30pm, 1/13/26 to go over the IC program. On 01/13/2026 at 1:16PM, the last 6 months of line listings were requested, the facility provided a partially completed December 2025 and January 2026. No line listings were provided for August, September, October or November 2025. On 01/13/2026 at 1:37PM, during the meeting to discuss the infection control program, IC nurse B confirmed that August, September, October and November 2025 are not completed for line listings. On 01/13/2026 at 1:39PM, IC nurse B was asked why they were so far behind on the infection control program. IC nurse B stated that were working a lot of hours on the floor providing direct care. IC nurse B stated, I believe I started working the floor in April 2025 until October 2025, a few times in November as well. Sometimes it was the whole week that I worked, it was 12hr shifts and it varied when I came in and left, but it was mostly on the midnight shift, we would work weekends as well. I filled in for admissions as well for a week and a half, then I cover for admissions when she is out of the building. On 01/13/2026 at 1:45PM, IC nurse B was asked if they had any outbreaks from August 2025 until today. IC nurse B stated, no, we have not had any outbreaks. IC nurse B was asked if they do any audits for hand hygiene, or anything related to infection control? IC nurse B stated, I initially delegated the audits for infection control to other staff, then I just started doing them myself. At one point I just stopped doing them completely and have not done any for 2025. We did our annual in-services, and we had two meetings that couldn't be completed due to someone being sick or me being sick and unable to perform my part. There were about 30 staff members that did not get the training on infection control or hand hygiene. IC nurse B was asked if they audit the kitchen or laundry? IC nurse B stated, I used to delegate the audits for both, then I did it myself, then I stopped doing it and have not completed an audit in 2025 for either of those departments. On 01/13/2026 at 1:55PM, IC nurse B was asked about R61 and having shingles in her left eye. IC nurse B stated that R61 has received all her antibiotics for her from [NAME] Eye; they never put any stop dates on it and that concerned me. They want the antibiotics going until she is completely healed. IC nurse B was asked why R61 was not on any precautions. IC nurse B stated, I initially put her in enhanced barrier precautions and then contact precautions. I really struggled with this one, she had no drainage or sores. I settled on putting her on enhanced barrier precautions. This surveyor and IC nurse B went to the room of R61 and verified that there were no precautions in place. A review of the electronic medical record revealed no orders or care plans for enhanced barrier precautions for R61. Review of the policy titled, infection Prevention and Control Committee, revealed,Duties of the Committee1. With the input of direct care staff, practitioners, the medical director, and the director of nursing services, assist in the development and implementation of written policies and procedures for the prevention and control of infectious or communicable diseases within the facility. 2.Assist in developing and implementing the written policies and procedures to identify and address infections within the facility. Review of the policy titled, Surveillance for Infections, revealed,Policy Statement The infection preventionist will conduct ongoing surveillance for healthcare-associated infections (HAI's0 and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	precautions and other preventative interventions.Gathering Surveillance Data2. The surveillance should include a review of any or all of the following information to help identify possible indicators of infection;a. laboratory recordsb. skin care sheetsc. infection control rounds or interviewsd. verbal reports from staffe. infection documentation recordsf. temperature logsg. pharmacy recordsh. antibiotic reviewi. transfer log/summaries

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to maintain ongoing review and implementation of the antibiotic stewardship program, resulting in the lack of monitoring of residents receiving antibiotics. Findings include:On 01/13/2026 at 1:16PM, the last 6 months of line listings was requested, the facility provided December 2025 and January 2026. No line listings or infection maps were provided for August, September, October or November 2025. On 01/13/2026 at 1:37PM, Infection Control (IC)l nurse B confirmed that August, September, October and November 2025 are not completed for line listing. IC nurse B was asked how they know who is on antibiotics in the facility. IC nurse B stated, I keep track of it on paper currently but haven't gotten it put into a line listing. No maps of infections were observed. On 01/13/2026 at 2:06PM, IC nurse B was asked what the nurses do if they suspect infection. IC nurse B stated, they will put in a nurses note and they will contact me and see if they meet McGeer's criteria. If someone presents with one symptom of UTI, we will do a three-day monitoring, if on day two they meet criteria then we will send a UA. IC nurse B was asked if the physicians document risk vs benefit for antibiotic use. IC nurse B stated, yes, for the most part they are pretty good at it. But I do have to keep up on them at time. Review of the policy titled, Infection Prevention and Control Committee, revealed, RecordkeepingThe infection prevention and control committee will advise administration and management about ensuring that records are maintained to document the following:3. Findings made during surveillance of antibiotic usage patterns Review of the policy titled, Surveillance for Infections, revealed,Gathering Surveillance Data2. The surveillance should include a review of any or all of the following information to help identify possible indicators of infection;a. laboratory recordsb. skin care sheetsc. infection control rounds or interviewsd. verbal reports from staffe. infection documentation recordsf. temperature logsg. pharmacy recordsh. antibiotic reviewi. transfer log/summaries

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent for the initiation and dose changes of psychotropic medication for one resident (R4) of four residents reviewed for unnecessary medications. Findings include: Resident #4 (R4): R4 is [AGE] years old and most recently admitted to the facility on [DATE] with diagnoses that include anxiety disorder, dementia with other behavioral disturbance, adjustment disorder and depression. R4 has been deemed incapable of making her own decisions. On 01/14/2026 at 12:41PM, record review of the electronic medical record (EMR) revealed that R4 was receiving the following psychotropic medications: -Citalopram 20mg daily, order date of 8/19/25 for depression.-Lorazepam 0.5mg three times a day, order date of 8/18/25 for agitation.-Zoloft 50mg daily, order date of 10/4/25 for depression.-Seroquel 50mg twice a day, order date of 11/24/25 for behavioral disturbance. On 01/14/2026 at 2:31PM, an interview was conducted with Social Worker (SW) A SW A was asked when the last time was that she spoke to the durable power of attorney (DPOA) for R4. SW A stated, I spoke with the DPOA in October of 2025 for hospice questions and I spoke with the second contact just before Christmas. The DPOA was supposed to be at the care conference in November of 2025 but was unable to attend. SW A was asked how they attempt to contact the DPOA. SW A stated, I usually try to reach him by phone; I know nursing has been trying to reach out to him as well for admission documentation that needs to be signed. SW A was asked who is responsible for obtaining informed consent for psychotropic medications. SW A stated that psych services will reach out and gets the informed consent for meds and nursing does that as well. SW A stated, I have an updated consent for Seroquel that needs to be signed, but the DPOA has not been into the facility yet and I haven't been able to contact him. SW A was asked if they were aware the last signed informed consent for psychotropic medication was from 2023 and there have been dosage changes since then. SW A stated, yes, I am aware of that. The DPOA does not live locally anymore, and they have moved down state, they aren't as available as before. Do you get informed consent for anti-psychotic, anti-depressant or anxiolytics? Yes, but we just do the informed consent for anti-psychotic medications. On 01/14/2026 at 3:03PM, review of the policy titled, Psychotropic Medication Use revealed,Informed Consent or Refusal1. Prior to initiating the use of, increasing the dose of, or switching to a different antipsychotic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal:a. non-pharmacological alternativesb. the indications and rationale for the recommendation.c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings): andd. the resident's/representative right to accept for decline the treatment. -No evidence can be located in the EMR that indicates the DPOA is aware of medication initiation or dosage changes.

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Great Lakes Rehabilitation Center	4180 Tittabawassee Road Saginaw, MI 48604

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure accurate advanced directives for one resident (R30) of one resident reviewed for advanced directives, resulting in the resident being listed as a full code when their wishes were to be a Do not resuscitate (DNR). Findings include: R30 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hypertension, fractures with routine healing, falls and chronic kidney disease. R30 was deemed capable of making her own decisions. On [DATE] at 10:00AM, record review of the electronic medical record (EMR) revealed that R30 had a signed physician's order for a full code, dated [DATE] at 15:40PM. A signed code status document that was scanned into the EMR revealed that R30 had elected to be a no for cardiopulmonary resuscitation (CPR) and no for mechanical ventilation, but yes to hospitalization. The form was signed and dated [DATE]. There is no care plan present for advanced directives.On [DATE] at 10:19AM, an interview was conducted with Social Worker (SW) A. SW A was asked who is responsible for completing the code status for residents? SW A stated, I do the care plans for code status, and the nurses do the orders and paperwork upon admission. S A was asked if R30 should she have an order for do not resuscitate (DNR) based on her signed code status in the EMR. SW A stated, yes, and she should have a matching care plan for that. Verified with the Social Services director that the physician order is for full code, there is no care plan present, and the signed code status is for a DNR with hospitalization only. SW A acknowledged this and stated they would correct it.

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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 to input stop dates for as needed psychotropic medications for two residents (Resident #16 and Resident #27). Findings include:Resident #16On 1/14/2026 at approximately 2:00 PM, a review was conducted of Resident #16's medical records and it indicated the resident admitted to the facility on [DATE] with diagnoses that included, Gastroenteritis and Colitis, Metabolic Encephalopathy, Dementia, Hypertension, Depression, Diabetes and Acute Kidney Failure. Further review of his records indicated the following:Physician Orders:Prochlorperazine (Antipsychotic medication) Maleate Oral Tablet 10 MG (milligram)Give 1 tablet by mouth every 6 hours as needed for nausea/vomiting. Ordered on 11/5/2025 without an end date.Care Plan:There was no mention of his usage of the antipsychotic medication in his careplan or any monitoring for adverse side effects.Pharmacy Review:12/2/25: Recommend discontinuing PRN (as needed) use of Prochlorperazine 10mg Q6H (every 6 hours) for this resident or reorder for a specific number of day. Handwritten on the form it stated, Hospice and signed by a facility practitioner on 12/8/25.On 1/14/26 at approximately 3:15 PM, Social Worker A was asked about the open-ended antipsychotic medication order. She reported she was not aware he was prescribed a current antipsychotic for nausea/vomiting or that the order was entered as needed and open ended. Resident #27On 1/13/2026 at 9:30 AM, a review was conducted of Resident #27's medical record and it indicated she admitted to the facility on [DATE] with diagnoses that included, Clavicle fracture, Acute Kidney Failure, Vascular Dementia, Hypertension, Psychotic Disturbance, Mood Disturbance and Anxiety. Resident #27 is not her own person and required the assistance of facility staff for her daily cares. Further review of her chart yielded the following:Physician Orders:Ativan (Antianxiety medications) Oral Tablet 0.5 mgGive 1 tablet by mouth every 6 hours as needed for anxiety and agitation. Ordered on 12/30/2025 with no end date. On 1/14/2026 at 12:20 PM, an interview was conducted with Social Worker A regarding Resident #27's prn Ativan order. She reported that the resident was crawling out of bed, eating her feces, screaming/yelling and many other behaviors. Since inception of the Ativan, it had appeared to be effective in decreasing her behaviors. Social Worker A stated she was aware the Ativan order did not have a stop date and emailed the DON (Director of Nursing) on Monday after she had completed an audit and found it. At the time of the discussion the order was still prn and open ended. Pharmacy Review:12/2/2026: Recommend discontinuing PRN use of Lorazepam 0.5mg Q6H for this resident or reorder for a specific number of day. The response stated to Continue PRN use of Lorazepam for __ days, as the benefit outweigh the wrists. Handwritten on the form it stated, Hospice and signed by a facility practitioner on 12/7/25.It can be noted for both residents that the pharmacy review indicated the inaccuracies of the medication order but due to the residents being on hospice the medications orders were not revised.Review was completed of facility policy entitled, Psychotropic Medication Use, revised 2/2025. The policy stated, psychotropic medications are not prescribed or administered on a PRN basis unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. the prescriber or attending physician believes it is appropriate to extend the prn order beyond 14 days.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely submit a Level 1 PASARR (Preadmission Screening and Resident Review) Screenings for one resident (Resident #31), resulting in Resident #31's PASARR not being completed within the annual timeframe or transmitted to OBRA (Omnibus Budget Reconciliation Act).Findings Include:On 1/13/2026 at 9:55 AM, a review was conducted of Resident #31's medical record and it revealed she was admitted to the facility on [DATE] with diagnoses that included, Hypotension, Bipolar Disorder, Adjustment Disorder with mixed Anxiety and Depressed mood and Major Depressive Disorder. Further review of Resident #31's records indicated the following:OBRA PASARR Correspondence:The last correspondence uploaded into the resident's chart was dated 6/25/2024 which indicated she did not meet criteria for a Level II evaluation by their local community mental health authority.A PASARR had not been submitted for Resident #31 in over a year. On 01/13/2026 at 4:34 PM, the facility provided a completed PASRR (DCH-3877) for Resident #31 that was signed as completed and submitted to OBRA on 9/19/2025. The response letter received from OBRA was dated 1/13/2026. On 01/13/2026 at 4:39 PM, an interview was conducted with Saginaw County OBRA Representative S, regarding Resident #31's response letter. She reported she recently reached out to the Administrator regarding their lack of submission of PASRR's. She believes they are creating the DCH 3877's in the system but did not press the submit button which transmits the document to OBRA. Representative S stated within the last year she has received less than 15 PASRR's from the facility. On 1/8/26 they did submit multiple PASRR's for review to her. On 01/14/2026 at 12:30 PM, Social Worker A stated since the change to electronic OBRA system she is no longer able to complete PASRR's. On 01/14/2026 at 1:15 PM, the Administrator was queried regarding the four-month gap in which the physician signed the PASRR's and correspondence was received from OBRA for Resident #31. The administrator explained since their past DON (Director of Nursing) resigned in the summer, they did not have access to the OBRA system until they found their Medical Director had access. In August/September 2025 they thought they had completed all facility PASRRs that were due/past due.Recently, they received a phone call from the OBRA representative who informed them they had not submitted any PASRRs. It was at this time they were informed it was two-step submission process, and they had only completed Step 1. All the PASRRs they completed in the fall were never submitted to OBRA but pending in their portal for transmission. The OBRA representative walked them through the full process so that they now have a good understanding of system and submission process. After the discussion they submitted all the pending PASRRs that were in the portal and have requested access for their current DON. There were 14 PASRR's the facility had pending to be transmitted. Review was conducted of the facility policy entitled, Coordination- Pre-admission Screening and Resident Review (PASRR) program, undated. The policy stated, .all residents admitted to the facility receive a Pre-admission Screening and Resident Review in accordance with State and Federal Regulations. Review was conducted of State of Michigan -OBRA -Specialized Nursing Home which stated, .In addition, persons residing in a nursing facility who are seriously mentally ill and/or have an intellectual / developmental disability are required to undergo a similar review annually or when there is a significant change in condition to determine whether they continue to require the services of a nursing facility or whether they require specialized mental health services. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:1. a) Facility Medical Director and Facility Administrator completed PASRR screeningand submitted PASRR screening to OBRA for each resident impacted by thisdeficiencyb) Request for Director of Nursing access to OBRA system, originally initiated on8/12/2025, has been re-requested on 1/14/2026.2. a) Facility Medical Director and facility Administrator will complete PASRRscreenings and submit screenings to OBRA for all residents by screening due dateuntil Director of Nursing OBRA access has been granted.b) PSARR (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedure has been reviewed and updated to include a changein the policy in which the facility will have a second designee with OBRA access as aback up in the event the Director of Nursing or primary designee is unable tocomplete resident screening.3. a) Education by Community Mental Health was provided through email and viaphone regarding how to complete the two-step process to Administrator and SocialWorker. Administrator and Social Worker have educated Director of Nursing.4.a) Social Worker will keep a tracking log to ensure all PSARR screenings arecompleted and submitted in accordance with due date.b) PASRR tracking will be monitored monthly during QAPI. The Administrator will beresponsible for continued facility compliance.5. Date of Compliance: 1/12/2026The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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F 0689 Level of Harm - Minimal harm or potential for 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 observation, interview and record review, the facility failed to follow care-planned interventions, update and/or revise the care-planned interventions and provide assistance for two residents (Resident #8, Resident #36) of two residents reviewed for accidents, resulting in unassisted Activities of Daily Living (ADL) care. Findings include. Resident #8 On [DATE], at 8:25 AM, Resident #8 was in their bathroom. They walked out of their bathroom to their bed. Their two-wheeled walker (2ww) was next to the foot of their bed on the left side. Resident #8 was asked if they were supposed to use the walker and Resident #8 offered that they use their wheelchair. Resident #8 stated they had lost their husband a long time ago and have been independent ever since. The call light was draped over the over bed table which was in the corner near the bathroom. Their wheelchair was at the foot of the bed approximately 10 feet away. On [DATE], at 8:52 AM, Resident #8 was observed in their wheelchair in the hallway outside of their room. On [DATE], at 11:45 AM, a record review of Resident #8's electronic medical record revealed an admission [DATE] with diagnoses that included fall on same level from slipping, tripping and stumbling, Dementia, Stroke and visual impairment. Resident had moderately impaired cognition. A review of the care plan Focus (the resident) has an ADL (activities of daily living) self-care performance deficit r/t: (related to) -Hx of mechanical fall -Hx of (L) Femural Neck Fx -Dementia -Fatigue -Limited Mobility -Limited ROM (range of motion) . Date Initiated: [DATE] Revision on: [DATE] Goal The resident will improve current level of function in ADL through the review date. Date Initiated: [DATE] Revision on: [DATE] Target Date: [DATE] Interventions/Tasks Ambulation: Resident requires extensive assist by 1 staff with 2ww/gait belt, proper footwear in room and to and from dinning room with wheelchair follow. Date Initiated: [DATE] . TOILET USE: The resident requires Limited X1 staff for toileting. Date Initiated: [DATE] Revision: [DATE] TRANSFER: The resident requires Limited X1 staff to move between surfaces as necessary with gait belt, two wheeled walker, and appropriate footwear Date Initiated: [DATE] Revision on: [DATE] A review of the care plan Focus (the resident) has an increased risk for fall r/t: hx of mechanical fall with (L) Femoral Neck Fx - Demenita -Forgets to use walker, does not use call light for assist . Does not use call light, self-transfers (observed ambulating in hall and in bathroom) Date Initiated: [DATE] Revision on: [DATE] Goal The resident will not sustain serious injury through the review date. Date Initiated: [DATE] Revision on: [DATE] Target Date: [DATE] Interventions/Tasks Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: [DATE] Ensure that The resident is wearing appropriate non skid, non slip footwear when ambulating or mobilizing in w/c. Date Initiated: [DATE] Revision on: [DATE] Follow facility fall protocol. Date Initiated: [DATE] Pt evaluate and treat as ordered or PRN Date Initiated: [DATE] The resident needs a safe environment (Such as: even floors free from spills and/or clutter, adequate, glare-free light, a working and reachable call light, the bed in low position at night; grab bars on walls near toilet, personal items within reach) Date Initiated: [DATE] Revision on: [DATE] A review of the Task:ADL-Walk in Room Look Back . WALK IN ROOM:SELF PEROFMARNACE - How resident walks between locations in his/her room . For the last 7 days the Not Applicable was check marked. According to the most recent comprehensive Minimum Data set Assessment, Resident #8 required setup or clean-up assistance (Helper sets up or clean up; resident completes activity. Helper assists only prior to or following the activity) for Walking 10 feet. For Chair/bed-to-chair transfer and Toilet transfer, the resident required Setup or clean-up assistance . On [DATE], at 4:30 PM, Resident #8 was in their room in their closet with the door closed. The light was on. Resident #8 exited the closet and sat in their wheelchair. The wheelchair was at the end of their bed and was facing towards the exit door. Resident #8 stood back up, walked back to their closet and shut off the closet light. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8 walked back to their wheelchair and sat down. Their ambulation was slow with a slight sidestep to the left. Their walker was next to the left side of bed. Resident #8 was asked if they ever use the walker and Resident #8 offered not often as they tapped on the walker. The call light remained in the same position draped over the table in the corner. Resident #8 again stated they're independent, their husband died at age [AGE] and I've been on my own since then. Outside of the resident's room there were no visible staff. Moments later, Nurse F was in the hallway and was asked if Resident #8 required assistance for transfers and ambulation and Nurse F stated, oh, she's independent. On [DATE], at 10:51 AM, Resident #8 was lying in bed under a blanket. The wheelchair was at the foot of the bed. The call light was draped over the over bed table in the same position as the day prior. On [DATE], at 10:56 AM, CNA K was asked why Resident #8's wheelchair would be locked at the foot of the bed and CNA K offered, she put it there. She doesn't always use her call light, and we check on her but she doesn't always ask for help. Resident #36 On [DATE], at 8:28 AM, Resident #36 was in their bathroom. Their wheelchair was approximately 1 foot from the toilet. Resident #36 was standing up facing the wall that housed a handrail. Resident #8 was not holding onto the rail and was using both hands to pull down their robe that was folded up and stuck in their incontinent brief. Resident #36 was asked if they needed assistance and Resident #8 while giggling stated, I don't know. Resident #36 grabbed the rail and sat down in their wheelchair. Resident #36 was asked if they could reach the call light and Resident #36 offered, I can't reach it. The call light string was out of reach of the resident. The resident had slippers on. On [DATE], at 3:15 PM, a record review of Resident #36's electronic medical record revealed an admission on [DATE] with diagnoses that included Age related cognitive decline, altered mental status and Osteoporosis. According to most recent Minimum data set assessment, the resident had moderately impaired cognition. According to the most recent comprehensive assessment, the resident required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) assistance for both Chair/bed-to-chair transfer and Toilet transfer. A review of the care plan Focus (the resident) has increased risk for fall . Dependent on wheelchair for mobility Date Initiated: [DATE] Revision on: [DATE] Goal The resident will not sustain serious injury through the review date. Date Initiated: [DATE] Revision on: [DATE] Target Date: [DATE] Interventions/Tasks Anticipate and meet The resident's needs. Date Initiated: [DATE] Revision on: [DATE] . A review of the care plan Focus (the resident) has an ADL self-care performance r/t: Hx of (R) Total Shoulder Athroplasty ([DATE]) . Date Initiated: [DATE] Revision on: [DATE] Goal The resident will be assisted daily with ADL's by staff Date Initiated: [DATE] Revision on: [DATE] Target Date: [DATE] Interventions/Tasks . TOILET USE: The resident requires EXT x 1 assist for toileting. Date Initiated: [DATE] Revision on: [DATE] TRANSFER: The resident requires EXT x1 staff with gait belt and proper footwear to move between surfaces. Date Initiated: [DATE] Revision on: [DATE] . A review of the care plan Focus (the resident) has impaired cognitive function or impaired cognitive function or impaired though processes r/t -Neurological symptoms Last BIMS score of 8 on [DATE] Date Initiated: [DATE] Revision on: [DATE] . Interventions/Tasks Cue, reorient and supervise as needed. Date Initiated: [DATE] Revision on: [DATE] . On [DATE], at 10:34 AM, Resident #36 was in their bathroom sitting on the toilet. Resident #8 ripped off their disposable incontinent brief that was soiled with urine and bowel movement. Resident #36 offered, I do it myself when asked if they needed assistance. Resident #36 remained on the toilet. Resident #36 giggled when asked if they could activate the call light which was near their left shoulder on the wall. On [DATE], at 10:36 AM, Nurse Q was in the hallway and was alerted Resident #8 was on their toilet unassisted. Nurse Q was unable to find a gait belt in Resident #36's room. Moments later, CNA K entered the bathroom and offered, she refuses to use the gait belt. Nurse Q left out and reentered the bathroom with a gait belt. Nurse Q attempted to place the gait belt on Resident #36 who refused the gait belt. CNA K was asked if the resident uses the call light for help and CNA K she doesn't put the light on and the only time she does if she has a bm (bowel movement) and wants to be cleaned. CNA (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	K was asked if the resident had therapy recently and CNA K offered, they pick her up every now and then. Nurse Q and CNA K was alerted the brief Resident #36 took off was soiled with BM. Nurse Q assisted the resident with perineal care. Resident #36 was assisted to a standing position. Resident #36 was asked if their bottom was sore as their buttocks and legs were reddened and Resident #36 offered, I get tired sitting here. During exit conference, the Administrator offered they couldn't do one on one with the residents and complained they couldn't restrain them as they questioned the concern of lack of supervision.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow standards of practice for urinary catheters and follow care planned interventions for two (Resident #60, 62) of two residents reviewed for urinary catheters, resulting in urinary catheter bags on the floor, no physician orders for urinary catheters with the likelihood of urinary catheter associated infections. Findings include. On 1/12/2026, at 10:30 AM, Resident #60 was lying in bed. They had a urinary catheter hooked to the right side of their bed. There was no dignity bag. Their urine was clear yellow in color. On 1/13/2026, at 8:39 AM, Resident #60 was in their room in their wheelchair. Certified Nursing Assistant (CAN) maria adjusted the urinary catheter bag and tubing under the wheelchair with their gloved hands. There was no dignity bag covering the urinary drainage bag. On 1/13/2026, at 10:15 AM, a record review of Resident #60's electronic medical record revealed an admission on [DATE] with diagnoses that included chronic kidney disease, retention of urine and anxiety disorder. Resident #60 had intact cognition. A review of the Physician Orders revealed no order to care for the urinary catheter. A review of the Admit/Readmit Screener Date: 1/10/2026 revealed . Bladder . Catheter Type/Size . 16 fr (French) with 10 cc (cubic centimeters) balloon . On 1/13/2026, at 11:49 AM, Resident #60 was sitting in the dining room at a table. Their urinary drainage bag was touching the floor without a dignity bag. On 1/13/2026, at 11:50 AM, the Director of Nursing (DON) was asked if they saw Resident #60's drainage bag touching the floor and the DON stated, I sure do. On 1/13/2026, at 4:37 PM, Infection Control (IC) Nurse B was questioned if Resident #60 was going to continue the use of the urinary catheter and IC Nurse B offered, they would check. IC Nurse B was alerted Resident #60's catheter bag was on the floor in the dining room. Resident #62 On 1/13/2026, at 11:52 AM, Resident #62 was lying in their bed. Nurse F entered to prepare their antibiotic medication. CNA J and L assisted the resident from the wheelchair to their bed. The resident had a urinary catheter drainage bag hooked under their wheelchair with amber colored urine in the bag and tubing. The urinary catheter drainage bag was unhooked and dropped to the floor. Once the resident was in bed, CNA J picked up the drainage bag off the floor and lifted the drainage bag above the level of the resident's bladder. The urine in the drainage tube drained back towards the resident. CNA J handed the drainage bag to CNA L . Both CNA J and CNA L assisted the resident with care and once the catheter bag was hooked to the right side of the bed frame, the urine drained back through the tube into the drainage bag. On 1/13/2026, at 1:30 PM, a record review of Resident #62's electronic medical record revealed an admission on [DATE] with diagnoses that included Pneumonia, pressure ulcer and Multiple Sclerosis. Resident #62 had intact cognition. A review of the care plan Focus (the resident) has an indwelling 16 Fr foley catheter . Interventions/Tasks CATHETER: The resident has a 16 Fr Indwelling foley catheter. Position catheter bag and tubing below the level of the bladder . Date Initiated: 01/08/2026 . On 1/13/2026, at 4:37 PM, IC Nurse B was alerted of the observation of Resident #62's urinary drainage bag that was on the floor and then held above their bladder with urine observed flowing back toward the resident . On 1/14/2026, at 10:11 AM, The DON was alerted of the observation of Resident #62's urinary bag observation the day prior. A review of the facility provided policy Catheter Care, Urinary 2-2025 revealed . Be sure the catheter tubing and drainage bag are kept off the floor. Ensure catheter bag had a privacy/dignity covering . Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder .

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	235442	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Lakes Rehabilitation Center	4180 Tittabawassee Road Saginaw, MI 48604

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and record review the facility to complete a comprehensive nutritional assessment and timely address weight loss for one resident (Resident #44) of one resident reviewed for nutrition.Findings Include:On 1/12/2025 at approximately 11:45 AM, Resident #44 was observed resting in bed. He stated he typically eats well at the facility but would like more food during meals.On 1/13/2025 at approximately 10:30 AM, a review was conducted of Resident #44's records and it indicated he admitted to the facility on [DATE] with diagnoses that included, Necrosis of left Femur, Acute and Chronic Respiratory Failure, Acute Embolism and Thrombosis and Osteoporosis. Further review of Resident #44's records indicated the following: Weights:12/17/2025 - 187.8 Lbs (pounds)10/3/2025 -199.3 Lbs 10/2/2025 - 201.2 Lbs 7/24/2025 -195.5 Lbs7/21/2025 -202.0 Lbs6/27/2025- 201.2 Lbs6/26/2025- 200.0 Lbs On 10/02/2025, the resident weighed 201.2 lbs. On 12/17/2025, Resident #44 weighed 187.8 lbs which is a -6.66% loss over two months.On 06/25/2025 (admission weight), the resident weighed 200 lbs. On 12/17/2025, Resident #44 weighed 187.8 lbs which is a -6.1% loss over six months. Progress Notes: 6/21/2025 at 11:27: Nutrition/Dietary Note: Met with (Resident #44) at bedside. He was in pain related to L (left) hip, stated not better since prior to surgery . He is on a regular diet with good intake at dinner last night. He is edentulous. Stated that he has dentures at home but rarely wears them, no trouble without them chewing. Ensure plus noted at bedside.There were no other notes related to Resident #44's weight loss that was indicated on 12/17/2025 nor were there any interventions placed to prevent further weight loss. Nutritional Assessments:6/21/2025- Mini Nutritional Assessment7/2/22025- Mini Nutritional Assessment10/22/2025- Mini Nutritional AssessmentThe mini nutritional assessment is a condensed tool that does not review totality of the resident as it relates to their nutrition. On 1/14/2026 at 8:45 AM, Resident #44 was observed in bed watching television. He was queried regarding his weight loss. He stated the facility has never weighed him and he was not worried about his weight currently. During the interview his breakfast was delivered and he stated he did not typically eat breakfast and would most likely not consume the meal. Further review was conducted of Resident #44's records and it indicated the following:Care Plan: .(Resident #44) has a nutritional problem or potential nutritional problem r/t (related to):Hx Idiopathic aseptic necrosis of left femur, aftercare following joint replacement surgery, dehydration, Gastrointestinal hemorrhage, anemia, Current Diet Order: Regular NAS Diet with thin liquids. (Diet changed 10/2-after re-admission from the hospital) .(Resident #44) will maintain adequate nutritional status as evidenced by no significant weight changes.RD to evaluate and make diet change recommendations PRN (as needed).On 1/14/2026 at 2:30 PM, an interview was conducted with Dietary Manager C regarding Resident #44s' weight loss. Manager C reported she requested a reweight in December 2025 after the weight of 187 was documented but it does not appear the reweight occurred. Manager C was queried if the weight loss was addressed and she stated she did not believe it was a true weight loss as his intake has not changed. She added he is a slower eater but some meals he receives double portions. As his record was reviewed there was no documentation in his chart of staff reapproaching for reweigh or any further clarity addressing the weight loss from last month.Manager C explained she completes the Mini Nutritional Assessments quarterly and the dietitian completes the comprehensive nutritional assessment on admission, annually and with change in condition. Manager C was unable to ascertain why Resident #44's full nutritional assessment was not completed upon admission. Review was conducted of the facility policy entitled, Nutritional Assessment, revised 2/2024. The policy stated, .as part of the comprehensive assessment, the nutritional assessment will be systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to administer medications per standards of practice for two residents (Resident #41, Resident #59) of eight residents reviewed during the medication administration task, resulting in a medication error rate of 6.67 percent with the likelihood of further medication errors. Findings include. On 1/13/2026, at 2:28 PM, During medication administration task with Nurse P, Nurse P prepared a Heparin injection for Resident #59. Nurse P drew up the Heparin medication into a 3 cc (cubic centimeter) syringe with a 1-inch needle and walked towards Resident #59's room. Nurse P was asked what medication and what route they were going to administer and Nurse P stated, Heparin IM (intramuscular) and then quickly stated no, sub q (subcutaneous). Outside Resident #59's room, Nurse P reached for Resident #59's door and was asked what size needle whas required for a sub q injection and were they sure of the physician's order. Nurse P clarified the order on Resident #59's electronic medical record and Nurse P again reached for the door. Nurse P was asked to stop and to find their nursing manager. Nurse P entered Nurse Manager B's office and asked for a sub q needle. Nurse Manager B was alerted of the observation with Nurse P. Nurse P held up the Heparin in the 3 cc syringe with the IM needle and asked Nurse Manager B for a sub q needle. Nurse P gathered a smaller sized syringe with the appropriate size needle and asked Nurse Manager B if they could use it and Nurse Manager B offered, yes. Nurse P drew up the Heparin into the correct syringe and administered the medication to Resident #59 with the correct size needle.On 1/13/2026, at 2:50 PM, a record review of Resident #59's electronic medical record revealed . Heparin Sodium (Porcine) Injection Solution 5000 UNIT/ML Inject 1 ml subcutaneously . On 1/14/2026, at 8:53 AM, During medication administration task, Nurse F gathered morning medications for Resident #41 to include Potassium chloride 30 milliequivalent which Nurse F crushed and administered to the resident orally. Nurse F offered that the resident was recently sent to the emergency room and that they were checking the resident for a change in condition. On 1/14/2026, at 12:48 PM, Nurse F was interviewed regarding the morning medication administration for Resident #41. Nurse F was alerted potassium should not have been crushed and Nurse F stated, Oh, because its extended release. Nurse F was asked if they had called the physician and alerted the physician of the crushed Potassium administration and Nurse F stated, NO, but they would. On 1/14/2026, at 2:00 PM, Medication administration task was completed with two significant medication errors out of a total of thirty medication administration observations which revealed a medication error rate of 6.67 percent. On 1/14/2026, at 2:52 PM, Pharmacist O was interviewed via telephone. Pharamcist O was asked if the order for Potassium chloride ER (extended release) was safe to crush and administer orally to Resident #41. Pharmacist O stated, No, it shouldn't be crushed and they could switch to liquid. A record review of the facility provided policy Administering Medications 2-2025 revealed Medications shall be administered in a safe and timely manner, and as prescribed . The individual administering medications must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to administer medications per standards of practice for two residents (Resident #41, Resident #59) of eight residents reviewed during the medication administration task, resulting in the likelihood of unwanted reactions such as hematoma, severe stomach pain and potentially dangerous, rapid increases in potassium levels in the blood. Findings include. On 1/13/2026, at 2:28 PM, During medication administration task with Nurse P, Nurse P prepared a Heparin injection for Resident #59. Nurse P drew up the Heparin medication into a 3 cc (cubic centimeter) syringe with a 1-inch needle and walked towards Resident #59's room. Nurse P was asked what medication and what route they were going to administer and Nurse P stated, Heparin IM (intramuscular) and then quickly stated no, sub q (subcutaneous). Outside Resident #59's room, Nurse P reached for Resident #59's door and was asked what size needle whas required for a sub q injection and were they sure of the physician's order. Nurse P clarified the order on Resident #59's electronic medical record and Nurse P again reached for the door. Nurse P was asked to stop and to find their nursing manager. Nurse P entered Nurse Manager B's office and asked for a sub q needle. Nurse Manager B was alerted of the observation with Nurse P. Nurse P held up the Heparin in the 3 cc syringe with the IM needle and asked Nurse Manager B for a sub q needle. Nurse P gathered a smaller sized syringe with the appropriate size needle and asked Nurse Manager B if they could use it and Nurse Manager B offered, yes. Nurse P drew up the Heparin into the correct syringe and administered the medication to Resident #59 with the correct size needle. On 1/13/2026, at 2:50 PM, a record review of Resident #59's electronic medical record revealed . Heparin Sodium (Porcine) Injection Solution 5000 UNIT/ML Inject 1 ml subcutaneously . On 1/14/2026, at 8:53 AM, During medication administration task, Nurse F gathered morning medications for Resident #41 to include Potassium chloride 30 milliequivalent which Nurse F crushed and administered to the resident orally. Nurse F offered that the resident was recently sent to the emergency room and that they were checking the resident for a change in condition. On 1/14/2026, at 12:48 PM, Nurse F was interviewed regarding the morning medication administration for Resident #41. Nurse F was alerted potassium should not have been crushed and Nurse F stated, Oh, because its extended release. Nurse F was asked if they had called the physician and alerted the physician of the crushed Potassium administration and Nurse F stated, NO, but they would. On 1/14/2026, at 2:52 PM, Pharmacist O was interviewed via telephone. Pharamcist O was asked if the order for Potassium chloride ER (extended release) was safe to crush and administer orally to Resident #41. Pharmacist O stated, No, it shouldn't be crushed and they could switch to liquid. A record review of the facility provided policy Administering Medications 2-2025 revealed Medications shall be administered in a safe and timely manner, and as prescribed . The individual administering medications must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . According to the U.S. Food and Drug Administration, Do not administer Heparin Sodium Injection by intramuscular injection because of the risk of hematoma (a collection of clotted blood that has leaked from damage blodd vessels into surrounding tissues, organs, or body spaces) at the injection site.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to administer an influenza vaccine for one resident (Resident #19) of five residents reviewed for immunizations. Findings include:R19 is [AGE] years old and admitted to the facility most recently on 03/25/2025 with diagnoses that include hypertension, dementia, acute kidney failure and muscle weakness. On 01/13/2026 at 2:31PM, record review of influenza, pneumococcal and COVID-19 immunization was conducted for five residents.R19 received an influenza vaccine on 01/30/2024. A scanned influenza immunization consent dated 01/07/2025 indicated that R19 consented to receiving the influenza vaccine. Record review of the EMR revealed that R19 had not received the influenza vaccine in 2025. On 01/13/2025 at 2:55PM, an interview was conducted with Infection Control (IC) nurse B. IC nurse B was asked if R19 had received an influenza vaccine in 2025. IC nurse was unsure if R19 had or not and said they would check. IC nurse B returned a few minutes later and stated that R19 had not received the vaccine and it was just missed. Review of the policy titled, Influenza Vaccine, revealed,Policy Interpretation and Implementation5. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record.