STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235458	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Grand Rapids	1950 32nd Street SE Grand Rapids, MI 49508

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview, and record review, the facility failed to ensure Certified Nursing Assistants (CNA's) yearly performance review was conducted resulting in the potential for CNA's to not be able to safely provide necessary care and services to residents, a lack of training, and the potential for unmet care needs.Findings include: On 10/23/25 at 12:48 PM, this writer requested verification of annual performance reviews for five sampled CNA files: (CNA H, M, OO, PP, and QQ). The facility was unable to provide the requested information. In an interview on 10/23/25 at 1:06 PM, Nursing Home Administrator (NHA) A reported that the facility had not completed annual performance reviews for the CNA staff.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2648348 and 2640731.Based on interview and record review, the facility failed to ensure residents were free from significant medication errors in 1 of 6 residents (Resident #101) reviewed for medication administration resulting in an Immediate Jeopardy beginning on 10/9/25 at approximately 9:00 AM when Resident #101 received another resident's medications which were administered by an agency nurse and nursing student. Resident #101 was found approximately one hour later and was noted to be lethargic and was hospitalized from [DATE]-[DATE] where she was diagnosed with acute metabolic encephalopathy (significant decline in brain function due to an underlying metabolic disturbance) and iatrogenic polypharmacy (harm caused by the administration of multiple medications). This deficient practice placed all residents residing in the facility at risk for significant medication errors. Findings include: The immediate jeopardy began on 10/9/25 when Resident #101 was administered another resident's medications and was sent to the hospital, where she was hospitalized from [DATE]-[DATE]. Resident #101 returned from the hospital on hospice services. Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on 10/22/25 at 9:00 AM. The surveyor confirmed by observation, interview, and record review that the immediacy was removed on 10/11/25 and the deficient practice was corrected on 10/21/25 prior to the start of the survey. Resident #101Review of an admission Record revealed Resident # 101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and essential hypertension (high blood pressure). Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 8/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #101 was moderately cognitively impaired. Review of Resident #101's Hospital Records dated 10/9/25 revealed, . Assessment and plan: Acute metabolic encephalopathy and iatrogenic polypharmacy . History of present illness: . (Resident #101) presents with somnolence (abnormal drowsiness) after taking another resident's medication. (Resident #101) will respond to verbal stimuli but does not engage in conversation. She is able to follow simple commands with squeezing fingers/wiggling toes. Per report, the patient (Resident #101) was in her usual state of health today when she was given another resident's medications. These included Bupropion 450 mg (antidepressant medication), Dronedarone 400 mg (antiarrhythmic medication used to treat certain heart dysrhythmias), Eliquis 5 mg (anticoagulant medication used to treat and prevent blood clots), Fluconazole 200 mg (antifungal medication used to treat fungal infections), Fludrocortisone 0.1 mg (corticosteroid medication used to manage the body's sodium and fluid balance), Gabapentin 900 mg (anticonvulsant medication used to treat seizures and nerve pain), Norco 5-325 mg (opioid pain medication), Synthroid 112 mcg (thyroid hormone medication used to treat hypothyroidism), Metoprolol 25 mg (beta blocker medication used to treat high blood pressure and chest pain), Midodrine 10 mg (vasopressor medication used to treat low blood pressure), Pantoprazole 40 mg (proton pump inhibitor used to reduce stomach acid), Torsemide 20 mg (diuretic used to treat high blood pressure and reduce edema (swelling) in the body . Assessment and plan dated 10/13/25: Interval history: Over the weekend was reportedly mostly normal on 10/11, 10/12 family reports that she (Resident #101) was hallucinating about cats and insects in the room. Subjective: Somnolent, does not awaken easily, quite confused per daughter at bedside . Neurological: Mental Status: She is lethargic. 10/13: pt. (Resident #101) is somnolent today and not able to participate with cares. SLP (Speech Language Pathology) ordered for concern regarding issues with swallowing over the weekend, but she isn't able to participate in the evaluation. Palliative care (specialized medical care for people with serious or life-threatening illnesses) following . 10/14: (Resident #101's family member) and (local hospice facility) met and intends to sign Resident #101 up for hospice . Review of the facility Incident Report dated 10/9/25 revealed, Nursing Description: At 9:39 AM, the nurse, accompanied by two student nurses, prepared medications for the (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	patient. Both student nurses verified and pulled the medications while the nurse rechecked each before placing them into the medication cup. Vital signs were obtained prior to administration, and the medications were given to the patient. While continuing the medication pass, it was noted that another patient had not yet received her medications, though the MAR (medication administration record) indicated they had been administered. Upon review, it was discovered that the medications for that patient had been given to the first patient in error. Resident Description: Resident Unable to give Description. Description: The nurse immediately assessed the affected patient (Resident #101), who was found to be lethargic. Vital signs were BP (blood pressure) 99/54, HR (heart rate) 72, RR (respiration rate) 16, SpO (oxygen saturation) 92%. The Director of Nursing (DON) and Nurse Practitioner (NP) were notified promptly. The NP reviewed the medications administered, consulted with medical support, and recommended hospital transfer for further evaluation. The patient's daughter was notified of the situation and transfer. The patient was transported via MMS (sic) to (local hospital) in stable condition. Level of Consciousness: Lethargic (Drowsy). Notes: patient responded appropriately oriented to person and disoriented to situation and time . Review of Resident #101's Progress Note dated 10/9/25 and documented by Nurse Practitioner (NP) BB revealed, . Nursing approached requesting my immediate attention due to the fact that Pt (Resident #101) received someone else's medications. The nurse reported that she was assisting a student nurse to administer the pt. her medication, not realizing that the other pt. who has a remarkably similar name and only one room away from pt, medications were inadvertently mixed up and given to pt. by mistake. A medication review of what pt. received revealed the following medications along with several vitamins and supplements were given: Zoloft 150 mg (antidepressant medication), dronedarone 400 mg, gabapentin 900 mg, Norco 5-325 mg, Robaxin 500 mg (muscle relaxant medication), Eliquis 5 mg, Fludrocortisone 0.1 mg, midodrine 10 mg, pantoprazole 40 mg, Wellbutrin (antidepressant) XL 450 mg, Diflucan 200 mg. Pt examined and Pt expressed she was terrified. Pt informed that we are sending her to the hospital to receive treatment and that I would stay with her until the ambulance arrives. Phoned Pt's daughter while at pt.'s bedside to report what incident and determine which hospital is preferred .Exam findings . Positive: Anxiety. Notes: Pt kept eyes closed and tried not to move while expressing her fear . Assessment and plan: F43.0- Acute stress reaction: pt. is experiencing an acute stress reaction to learning she received the wrong medications and the implications that may have to her health and life . Z77.9 Other contact with and (suspected) exposures hazardous to health: pt. received a tremendous amount of medications not intended for her. Her life depends on immediate transport to the hospital for treatment . In an interview on 10/20/25 at 2:17 PM, NP BB reported that she was notified by agency Licensed Practical Nurse (LPN) J on 10/9/25 that Resident #101 had received the wrong resident medications. NP BB reported that she immediately went to assess Resident #101 who she found to be lying in bed with her eyes closed. NP BB reported that Resident #101 was able to open her eyes and talk, but she did not want to because she was scared. NP BB confirmed that was very concerned about the number of medications that she had received and the various conditions that the medications were used to treat. NP BB reported that she had concerns that Resident #101 had the potential to experience serotonin syndrome (A serious drug reaction. It is caused by medications that build up high levels of serotonin in the body) and the potential for cardiac complications due to the large doses of antiarrhythmicmedication and cardiac medications that she received. NP BB reported that she was also concerned about the large dose of gabapentin that Resident #101 received. NP BB confirmed that Resident #101 had an allergy to Norco, and that she had also received Norco during this medication error. NP BB reported that she ordered Resident #101 be sent to the hospital because of her concerns with the potential harm caused to Resident #101 from receiving large doses of medications not ordered for her. In an interview on 10/20/25 at 2:45 PM, Family Member (FM) D reported she was notified by NP BB on 10/9/25 that Resident #101 was given the wrong resident's medications, and that the facility was sending Resident #101 to the hospital. FM D reported that she met Resident #101 at the hospital, where she noted (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #101 to be non-responsive. FM D reported that Resident #101 slowly became more arousable during her stay in the hospital, but she also became much more confused, and the decision was made to activate Resident #101's durable power of attorney, which was followed by Resident #101 being enrolled into hospice services due to her decline. FM D reported that prior to the medication error incident on 10/9/25, Resident #101 was able to communicate well and was alert and oriented x3, able to feed herself, and required one person assistance from staff with activities of daily living (ADL) care. FM D reported that Resident #101 was discharged from the hospital on [DATE], but that she was still incredibly weak, and that the goal was to provide comfort care to Resident #101. FM D voiced concerns that the facility should have identified the potential for a medication error to happen, as Resident #101's room was next to a resident with the same first and middle name, and that their last names started with the same initial and were similar in sound, FM D reported that there had been multiple occurrences of staff mixing up Resident #101 and the other resident, and she had voiced concern about the residents being so close together with similar names. In an interview on 10/20/25 at 10:28 AM, LPN J confirmed she was the nurse that oversaw Resident #101 receiving the wrong resident medications. LPN J reported that she was an agency nurse at the facility, and she had not worked on Resident #101's unit prior to the 10/9/25. LPN J reported that she was assigned to have two nursing students with her, and that she was allowing the nursing students to prepare medications and dispense the medications to the residents. LPN J reported that one of the nursing students reviewed the medication orders for the resident in the room next to Resident #101 as they dispensed them, and then LPN J and the second nursing student were checking the medications to ensure that they were correct. LPN J reported that after the medications were prepped, she and the two nursing students went into Resident #101's room and asked her to confirm her name. LPN J reported that Resident #101 did state her first and last name, and then nursing student (NS) P administered the medications to her. LPN J reported that Resident #101 was able to engage in a casual conversation and would have been able to state her birthdate if she had been asked. LPN J confirmed that she or the nursing students did not notice that Resident #101 had said a different last name. LPN J reported that she did not verify Resident #101's birthdate, room number, or the picture in the MAR (medication administration record). LPN J confirmed that she was not familiar with Resident #101 or the resident that medications were given to Resident #101. LPN J reported that about an hour after Resident#101 received the wrong medications, she went to give the other resident her medications and noticed that they were already documented as administered. LPN J reported that she realized that she and the nursing students had administered the wrong medications to Resident #101 and she went to assess Resident #101 where she found her to be very lethargic. LPN J reported that she notified the Director of Nursing (DON) B and NP BB immediately, and they took over the care of Resident #101 after that. LPN J reported that she thought it was an accident waiting to happen to have two residents next to each other with the same first and middle name, and very similar last names in room next to each other. LPN J reported that she had never had nursing students follow her before, and that the facility and the nursing students did not give her any instruction on what the nursing students were allowed to do with her. LPN J reported that she had worked at the facility a few times, but she had never worked on the unit that Resident #101 was on. In an interview on 10/9/25 at 3:19 PM, LPN W reported he had cared for Resident #101 for several years, and that he was very familiar with her. LPN W reported Resident #101 was cognitively intact, and able to communicate with staff. LPN W confirmed that Resident #101 was able to communicate her name and date of birth . In an interview on 10/20/25 at 11:16 AM, NHA A and DON B reported they were both made aware of the medication incident on 10/9/25 right after it was discovered. DON B confirmed that a nursing student had administered the medications to Resident #101 under the supervision of LPN J. DON B and NHA A confirmed that Resident #101 was in a room right next to a resident that had the same first and middle name, and that Resident #101 and the other resident had very similar last names. NHA A and DON B also confirmed that they did not have a facility policy for student nurses at the time of the incident, and (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that they were no longer allowing agency nurses to work with nursing students. In an interview on 10/20/25 at 12:01 PM, Clinical Instructor (CI) K reported she had been made aware of Resident #101 receiving the wrong medications on 10/9/25. CI K reported the educational institution's policy was that nursing students were not supposed to administer medications with a nurse at the facility, and that they were only allowed to dispense and administer medications under the supervision of a clinical instructor. CI K reported that she could not confirm or deny if one of the nursing students had administered the medications because she was not present to observe. This writer asked for the contact information for the two nursing students that were involved in the incident. On 10/20/25 at 4:12 PM, this writer received a call from the Nursing School (name redacted) Faculty Director (FD) HH. FD HH reported that he wanted to present during this writer's interviews with the nursing students, and he arranged meetings with this writer and the nursing students. In an interview on 10/21/25 at 12:25 PM, Nursing Student (NS) II reported she did not recall the medication error, and that she could not remember any details of the medication administration for Resident #101. NS II was unable to report if LPN J had asked Resident #101 for her name prior to administering her medications. NS II reported she did not administer or dispense any medications. In an interview on 10/21/25 at 12:53 PM, NS P reported she had mostly observed LPN J on 10/9/25. NS P reported she did not dispense or administer medications under the supervision of LPN J. When asked by this writer why LPN J, DON B and the facility incident report indicated that she had prepared and administered the medications to Resident #101, NS P reported that did not know why. NS P reported she did not recall if LPN J had asked Resident #101 her name prior to giving her medications. In a follow up interview on 10/21/25 at 12:45 PM, FD HH reported he had met with the nursing students prior to this writer's interviews but stated that I did not coach them on what they were allowed to say or not say. It was noted that this writer had not queried FD HH about coaching the nursing students. In an interview on 10/21/25 at 12:30 PM, DON B reported she had been told on 10/9/25 by LPN J and NS P that NS P had dispensed and administered the medication that was given to Resident #101. DON B confirmed that she reported that NS P had administered the medications to Resident #101 to CI K. DON B confirmed that she was not aware that the nursing students were not supposed to administer medications without their clinical instructor present. DON B confirmed that the facility did not have a policy for how to navigate nursing students at the facility.In an interview on 10/20/25 at 12:29 PM, Facility Pharmacist (FP) L reported that as a pharmacist, she would have concerns with Resident #101 receiving such a high dose of Bupropion because that type of medication takes time to build up in the system, and there was a potential for lethargy (unusually tired), seizures. mild to moderate tachycardia (abnormally fast heart rate), neurological disturbances (wide range of conditions such as sensory changes, motor problems, cognitive impairment, and behavioral changes), tremors (rhythmic movement of body part that is out of control), dry mouth, headache and insomnia (restlessness). FP L reported that Resident #101 taking Fluconazole also increased her risk of seizures, and other expected side effects included nausea and vomiting. FP L reported that Resident #101 had the potential to experience sleeplessness, nervousness and anxiety from taking Levothyroxine 112 mcg. FP L reported that Resident #101 had the potential to experience electrolyte imbalances, hypotension (low blood pressure), dehydration, tachycardia, and headache from taking the Torsemide 20 mg. FP L reported that Resident #101 had the potential to experience QT prolongation (problem with the electrical system in your heart taking too long to recharge. This issue can lead to a life-threatening type of abnormal heart rhythm), lethargy, somnolence, and tachycardia from taking Zoloft 75 mg. FP L reported that Resident #101 had the potential to experience increased creatinine levels (waste from protein and muscle breakdown), diarrhea, nausea and vomiting from taking Dronedarone 400 mg. FP L reported that Resident #101 had the potential for increased bleeding and bruising from taking Eliquis 5 mg, and she had the potential for arrythmias and seizures due to taking Flu cortisone 0.1 mg. FP L reported that Resident #101 had the potential for hypotension, nausea, vomiting, and tachycardia from taking Methocarbamol 500 mg. FP L reported that Resident #101 had the potential to experience (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2648348 and 2640731.Based on interview, and record review, the facility failed to administer the facility in a manner that ensures the highest practicable physical well-being of each resident by: 1.) ensuring that the facility had an active contract with a nursing school, 2.) maintaining and implementing policies/procedures for nurses working with nursing students, and 3.) ensure medication administration policies were based on acceptable clinical standards for resident verification, resulting in Resident #101 receiving the wrong resident medications, which were administered by a nursing school student under the supervision of an agency nurse, which lead to Resident #101 being hospitalized from [DATE]-[DATE] with diagnoses of metabolic encephalopathy (significant decline in brain function due to an underlying metabolic disturbance) and iatrogenic polypharmacy (harm caused by the administration of multiple medications). Findings include: Resident #101Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 8/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #101 was moderately cognitively impaired. Review of Resident #101's Hospital Records dated 10/9/25 revealed, . Assessment and plan: Acute metabolic encephalopathy and iatrogenic polypharmacy . History of present illness: . (Resident #101) presents with somnolence (abnormal drowsiness) after taking another resident's medication. (Resident #101) will respond to verbal stimuli but does not engage in conversation. She is able to follow simple commands with squeezing fingers/wiggling toes. Per report the patient (Resident #101) was in her usual state of health today when she was given another resident's medications. These included Bupropion 450 mg (antidepressant medication), Dronedarone 400 mg (antiarrhythmic medication used to treat certain heart dysrhythmias), Eliquis 5 mg (anticoagulant medication used to treat and prevent blood clots), Fluconazole 200 mg (antifungal medication used to treat fungal infections), Fludrocortisone 0.1 mg (corticosteroid medication used to manage the body's sodium and fluid balance), Gabapentin 900 mg (anticonvulsant medication used to treat seizures and nerve pain), Norco 5-325 mg (opioid pain medication), Synthroid 112 mcg (thyroid hormone medication used to treat hypothyroidism), Metoprolol 25 mg (beta blocker medication used to treat high blood pressure and chest pain), Midodrine 10 mg (vasopressor medication used to treat low blood pressure), Pantoprazole 40 mg (proton pump inhibitor used to reduce stomach acid), Torsemide 20 mg (diuretic used to treat high blood pressure and reduce edema (swelling) in the body . Assessment and plan dated 10/13/25: Interval history: Over the weekend was reportedly mostly normal on 10/11, 10/12 family reports that she (Resident #101) was hallucinating about cats and insects in the room. Subjective: Somnolent, does not awaken easily, quite confused per daughter at bedside . Neurological: Mental Status: She is lethargic. 10/13: pt. (patient- which is Resident #101) is somnolent today and not able to participate with cares. SLP (Speech Language Pathology) ordered for concern regarding issues with swallowing over the weekend, but she isn't able to participate in the evaluation. Palliative care (specialized medical care for people with serious or life-threatening illnesses) following . 10/14 (Resident #101's family member) and (local hospice facility) met and intends to sign Resident #101 up for hospice . Review of the facility Incident Report dated 10/9/25 revealed, Nursing Description: At 9:39 AM, the nurse, accompanied by two student nurses, prepared medications for the patient. Both student nursesverified and pulled the medications while the nurse rechecked each medication before placing them into the medication cup. Vital signs were obtained prior to administration, and the medications were given to the patient.While continuing the medication pass, it was noted that another patient had not yet received her medications, though the MAR (medication administration record) indicated they had been administered. Upon review, it was discovered that the medications for that patient had been given to the first patient (Resident #101) in error . In an interview on 10/20/25 at 10:28 AM, Licensed Practical Nurse (LPN) J confirmed she was the nurse that oversaw Resident #101 receiving the (continued on next page)

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	235458	A. Building B. Wing	11/24/2025

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wrong resident medications. LPN J reported that she was an agency nurse at the facility, and she had not worked on Resident #101's unit prior to the 10/9/25. LPN J reported that she was assigned to have two nursing students with her, and that she was allowing the nursing students to prepare medications and dispense the medications to the residents. LPN J reported that one of the nursing students reviewed the medication orders for the resident in the room next to Resident #101 as they dispensed them, and then LPN J and the second nursing student were checking the medications to ensure that they were correct. LPN J reported that after the medications were prepped, she and the two nursing students went into Resident #101's room and asked her to confirm her name. LPN J reported that Resident #101 did state her first and last name and then Nursing Student (NS) P administered the medications to her. LPN J confirmed that neither she or the nursing students noticed Resident #101 said a different last name. LPN J reported that she had not verified Resident #101's birthdate, room number, or the picture in the MAR (medication administration record). LPN J reported that she had not received any guidance from the facility on what nursing students were allowed or not allowed to do, and she had assumed that they were allowed to pass medications with her supervision. In an interview on 10/20/25 at 11:16 AM, Nursing Home Administrator (NHA) A and Director of Nursing (DON) B reported they were both made aware of the medication error on 10/9/25 right after it was discovered. DON B confirmed that a nursing student had administered the medications to Resident #101 under the supervision of LPN J. DON B and NHA A reported that immediately after the incident, the facility removed nursing students from following agency nurses. NHA A and DON B were unable to provide the document guidance facility nurses received regarding what nursing tasks a student was allowed to perform when shadowing a facility nurse. In a telephone interview on 10/20/25 at 12:01 PM, Clinical Instructor (CI) K reported she had been made aware of Resident #101 receiving the wrong medications on 10/9/25. CI K reported that the educational institution's policy was that nursing students were not supposed to administer medications with a nurse at the facility, and that they were only allowed to dispense and administer medications under the supervision of a clinical instructor. CI K reported that she had not spoken with LPN J prior to having the nursing students follow her, and she assumed that the nursing students would ensure that the nurses knew what they were allowed to do and not do. In an interview on 10/21/25 at 12:45 PM, Faculty Director (FD) HH reported nursing students were not supposed to complete any clinical task, such as passing medications without the direct supervision of the clinical instructor. On 10/20/25 at 2:06 PM, NHA A provided a contract for a different nursing school and was unable to provide a contact with the nursing school from which the nursing students were enrolled when the medication error occurred with Resident #101. NHA A was unable to provide any facility policies related to student nurse roles or allowed tasks. In an interview on 10/20/25 at 3:09 PM, Clinical Instructor (CI) GG reported he was an instructor at the same Nursing College that had been at the facility on 10/9/25, and that he had a new group of nursing students in the facility for the week. CI GG reported nursing students were not allowed to complete any treatments or administer medications without the direct supervision of their clinical instructor.In a follow up interview on 10/20/25 at 3:15 PM, NHA A reported she was not aware of the nursing school that this writer had requested the contract with. NHA A reported that the facility did not work with the nursing school this writer had inquired about. This writer informed NHA A that the nursing school was in the building at the time completing a clinical rotation. NHA A then met with CI GG and reported to this writer that she would continue to look for the contract that the facility had with that nursing school. In an interview on 10/21/25 at 12:30 PM, DON B reported she had been told on 10/9/25 by LPN J that NS P had dispensed and administered the medication that was given to Resident #101. DON B confirmed that she reported that NS P had administered the medications to Resident #101 to CI K. DON B confirmed that she was not aware that the nursing students were not supposed to administer medications without their clinical instructor present. DON B confirmed that the facility did not have a policy for how to navigate nursing students at the facility, and that they had not been educating the facility nurses on what they were allowed to let nursing students assist with when they (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were shadowing the facility nurses. In an interview on 10/21/25 at 9:06 AM, Human Resources (HR) S reported she was not aware of the facility's partnership with the nursing school, and she was not involved in ensuring that the faculty and nursing students and the school were screened prior to their clinical rotation at the facility. In an interview on 10/21/25 at 9:15 AM, Regional Human Resources (RHR) DD reported she was not aware of the facility's partnership with the nursing school, and she was not involved in ensuring the school, the faculty, and the nursing students underwent proper screenings prior to their clinical rotation at the facility. RHR DD reported that the facility's [NAME] President of Clinical Operations (VPCO) E was responsible for all of the facility nursing school contracts. In an interview on 10/21/25 at 9:36 AM, VPCO E reported she was not aware of the nursing school that was currently in the facility, and that she was unable to confirm if the facility had a contract with the nursing school. In an interview on 10/21/25 at 8:47AM: NHA A reported she had discovered that the nursing school that was currently in the facility for a clinical rotation was based out of another state. NHA A confirmed that she was still trying to find a contract that the facility had with the school. NHA A did not know who was responsible for ensuring that the nursing school's faculty and students were screened prior to starting a clinical rotation at the facility. In a follow up interview on 10/21/25 at 2:00 PM, NHA A reported the facility was able to determine that they did not have a contract with the nursing school. NHA A reported that the facility's previous owner had a contract with the nursing school, but since the facility took ownership in August 2024, the facility had not had a contract with the nursing school. NHA A confirmed that the nursing school had continued to come to the facility since August 2024 for clinical rotations without a contract in place. NHA A confirmed that the facility was not aware of who, if anyone, was screening the nursing school faculty and students before they were at the facility caring for the residents. NHA A confirmed that the facility did not have any current policies regarding nursing students and clinical rotations. The six rights of medication administration include: 1) the right medication, 2) the right dose, 3) the right client, 4) the right route, 5) the right time, 6) the right documentation. To identify a client correctly, the nurse checks the medication administration form against the client's identification bracelet. When asking the client's name, the nurse should not merely speak the name and assume that the client's response indicates that he or she is the right person. Instead, the nurse asks the client to state his or her name. (Fundamentals of Nursing, 6th edition, 2005, pgs. 841-842.)Review of the facility's Medication Administration policy dated, 8/7/23 revealed, General Instructions: Medications are administered in accordance with the following rights of medication administration. Right resident, right medication, right dose, right route, right time and frequency, right documentation, right of resident to refuse, and right clinical indication . Procedure: Administer medication: Knock on door and request entrance. Introduce self, explain medication administration need, and provide privacy. Identify resident by calling name and referring to photo . The policy did not indicate that the nurse should ask the residents name, and it was optional to review a photo for second verification or to verify those who are unable to communicate. Please see F760 and F838 for additional information.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and update the facility assessment after changes which would require substantial modification which includes an assessment of policies and procedures, training programs, education, training and competencies of direct care staff- both employees and those who provide services under contract, and contracts/memorandums of understanding or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies resulting in the potential for unidentified resources necessary to provide care and services to the resident populationFindings include: Review of the Facility assessment dated [DATE]- 6/31/25 indicated that the facility assessment which was documented as reviewed on 6/3/25 did not include a facility nursing assistant, resident, or resident representative as part of the assessment review. The assessment did review staffing needs but had not been updated or reviewed after 6/2025. It was noted that the facility had been cited for staffing in August 2025. The facility assessment did not include the staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population. The facility assessment did not include services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies. The facility assessment did not include all personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care or contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies. During the survey, the writer identified that the facility had not completed annual performance reviews for Certified Nursing Assistants (CNA's) or ensured that the CNA's were completing the 12-hour in-service education based on the annual performance review. The writer also identified that the facility had a nursing school to conduct clinical rotations at the facility without an active contract, and without determining what training and any competencies related to resident care the students had completed prior to providing resident care. In an interview on 10/23/25 at 1:06 PM, Nursing Home Administrator (NHA) A reported the facility was purchased in August 2024. NHA A reported that she had completed the first assessment for the facility in June 2025, and that she had completed the facility assessment as a look back period from 7/2024-6/2025. NHA A confirmed that the facility assessment had not been reviewed and updated after June 2025. Please see F760, F835, F730 and F947 for additional information.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview, and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for Certified Nursing Assistants (CNA's) as determined by the yearly performance review, and ensure a total of 12 hours of yearly education, resulting in the potential for CNA's to not be able to safely provide necessary care and services to residents, a lack of training, and the potential for unmet care needs.Findings include: On 10/23/25 at 12:48 PM, this writer requested verification of annual in-service education for five sampled CNA files: (CNA H, M, OO, PP, and QQ. The facility was unable to provide the requested information. In an interview on 10/23/25 at 1:06 PM, Nursing Home Administrator (NHA) A reported that the facility had not completed annual reviews for the CNA staff, and therefore, the facility was not ensuring that the CNA's at the facility had completed the 12 hours of in-service education based on the annual performance reviews.