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	06/03/2026

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to promote dignity and respect in 2 (Resident #306 and Resident #309) of 5 residents reviewed for dignity resulting in unmet care needs, feelings of diminished self-worth, sadness, and frustration. Findings include: Resident #306Review of an admission Record revealed Resident #306 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression, muscle weakness, and repeated falls. Review of a Minimum Data Set (MDS) assessment for Resident #306, with a reference date of 4/17/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #306 was cognitively intact. In an observation and interview on 5/27/26 at 10:01 AM, Resident #306 was lying in her bed talking to this writer and Wound Care Licensed Practical Nurse (WCLPN) T. Resident #306 reported feeling frustrated with the care that she received at the facility. Resident #306 reported that staff at the facility would frequently ignore her call light when she would activate it to ask for help with care, or they would enter her room and turn off her call light before addressing her needs. During an observation on 5/29/26 at 8:33 AM, This writer noted that Resident #306's call light had been activated since 7:46 AM (47 minutes). It was also noted that there were 4 other call lights on the same hall as Resident #306. In an observation and interview on 5/29/26 at 8:55 AM, Resident #306 confirmed that her call light had been activated for assistance since 7:46 AM. Resident #306 reported it was common for her to have to wait for over an hour for her call light to be answered. Resident #306 voiced frustration regarding the long call light wait times, and reported feeling like the staff just could care less about what we (residents at the facility) need. They make me feel like I am bothering them every time I ask for help. On 5/29/26 at 9:00 AM, Certified Nursing Assistant (CNA) R entered Resident #306's room and turned off her call light. Noted that Resident #306's call light had been activated (1 hour and 27 minutes after Resident #306 activated her call light). Resident #309Review of an admission Record revealed Resident #309 was originally admitted to the facility on [DATE] with pertinent diagnoses which included major depressive disorder, generalized anxiety disorder, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #309, with a reference date of 6/2/26 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #309 was moderately cognitively impaired. Review of Section GG: Functional Abilities revealed that Resident #309 required substantial/maximum assistance with toileting. During an observation on 5/29/26 at 10:36 AM, this writer noted that the facility's call light board at the 300-hall nursing station indicated that Resident #309's call light was activated on 8:51 AM. As this writer was looking at the call light board, Certified Nursing Assistant (CNA) R looked at the call light board and then went to Resident #309's room at 10:41 AM. At 10:43 AM, CNA R exited Resident #309's room. It was noted that Resident #309's call light had been turned off. During an observation on 5/29/26 at 10:43 AM, this writer entered Resident #309's room and noted a strong smell of urine. Resident #309 was lying in his bed in a soiled hospital gown, with a soiled brief, pad, and sheets. Resident #309 yelled out as this writer entered his room, I need to be changed! Resident #309 reported he turned his call on to get help with being changed more than an (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hour prior to when CNA R entered his room. Resident #309 reported he was lying in a soiled brief, and that he had turned his call light on several times throughout the night and morning to get changed, but staff just turned off the light, said they would come back, but never did. Resident confirmed that he had asked CNA R to change him, and she said she would get his aide and be back, and then she left his room. Resident #309 voiced frustration about being left wet and soiled overnight. Resident #309 reported he felt embarrassed that he had to lay in soaked briefs, and he felt like the staff did not care about him, and he was so angry that the facility treated him so poorly. Resident #309 reported that it was common for the staff to ignore him all night and day because they don't like me or care. It was noted that Resident #309's call light was attached to his bed, and out of his hand. Review of Resident #309's toileting task on 5/29/26 at 10:50 AM indicated that staff had last documented incontinence care on 5/28/26 at 20:50 (8:50 PM). During an observation on 5/29/26 at 10:56 AM, CNA R returned to the 300 hall with 3 students that she was instructing to check on residents. CNA R went into the room next to Resident #309 and then two rooms across from Resident #309 to check in with the residents. CNA R then instructed the students to follow her to the other end of the hall to complete resident checks. Noted that CNA R did not enter Resident #309's room to complete a resident check. During an observation on 5/29/26 at 11:03 AM, Scheduler/CNA KK entered Resident #309's room and was overheard asking Resident #309 if she could complete her advocate rounds with Resident #309. Scheduler/CNA KK asked Resident #309 if staff had been kind, courteous and friendly? Resident #309 stated no. Scheduler/CNA KK then asked Resident #309 if his call light had been answered timely since the last time he was asked? Resident #309 stated no. Resident #309 was then overheard stating that he needed to be changed. Scheduler KK exited Resident #309's room after asking all of the advocate round questions. It was noted that she did not provide incontinence care to Resident #309. In an interview on 5/29/26 at 11:13 AM, Scheduler/CNA KK reported that Resident #309 did not report any care concerns to her. Scheduler/CNA KK then reported Resident #309's liked to hold on to his call light in his hand and would refuse to let staff remove the call light, which is why Resident #309's call light had been activated for over an hour earlier that morning. Noted that this writer did not ask Scheduler/CNA KK about Resident #309's call light being activated earlier that morning for over an hour. Scheduler/CNA KK reported that Resident #309 did not report that he needed assistance. During an observation on 5/29/26 at 11:23 AM, Resident #309 began yelling out help! repeatedly. Each time Resident #309 yelled out for help, his tone got louder. Noted that this surveyor could hear Resident #309 yelling out for help at the opposite end of the hall. At 11:23 AM, CNA R returned to the 300 hall and went into another resident room and did not respond to Resident #309's calls for help. During an observation and interview on 5/29/26 at 11:24 AM, Licensed Practical Nurse (LPN) S entered Resident #309's room and then exited his room at 11:25 AM. As LPN S was exiting Resident #309's room, this writer queried as to what Resident #309 was yelling out for, and she reported He does this all the time, he will say he wants to be changed, but he won't even be wet, he has a lot of behaviors. When asked if LPN S checked Resident #309's brief to see if he was soiled, she stated that she did not check Resident #309's brief.During an observation and interview on 5/29/26 at 11:31 AM, Certified Nursing Assistant (CNA) NN entered Resident #309's room with care supplies and then exited his room at 11:33 AM. CNA NN reported that she went into Resident #309's room to set everything up so that she could provide care to Resident #309 when she was done providing care for another resident. During an observation on 5/29/26 at 11:52 AM, Resident #309 activated his call light. At 11:58 AM, This writer entered Resident #309's room and noted a new brief that was sitting on his tray table with an incontinence pad inside the brief. Resident #309 reported that he had been told by CNA NN she would return to change him as soon as she could. Resident #309 again reported feelings of humiliation and anger towards the facility staff for the way that they treated him. Resident #309 reported if he didn't yell out for help, that they would never come to help me. They don't like me, it makes me feel like crap. On 5/29/26 at 12:02 PM, CNA NN entered Resident #309's room to assist with incontinence care. CNA NN removed Resident #309's blanket from him and confirmed that (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #309 was lying in a soiled brief. CNA NN stated to Resident #309 You definitely have not been changed since last night. Resident #309 again confirmed to this writer and CNA NN that he had not received care since the evening before. As CNA NN provided perineal care (peri care-is the hygienic cleaning and maintenance of the genital and anal areas to prevent infection, skin breakdown, and maintain comfort) to Resident #309, he reported a burning and itching on his buttocks area. CNA NN cleaned Resident #309's buttocks area and it was noted that Resident #309's skin looked red and irritated. In an interview on 5/29/26 at 1:34 PM, CNA NN confirmed that she was the staff member assigned to take care of Resident #309 that day, and that 12:02 PM was the first time that she had been in Resident #309's room to provide care to him. CNA NN reported that she was new to the unit, and that the residents on that hall required a lot of assistance, and she had been trying to catch up all morning. CNA NN reported that it was common for residents at the facility to go several hours without care, especially on nights. CNA NN reported that it was common for the night shift staff to not complete care on residents throughout the night, so she would often find residents wet and soiled in the morning. CNA NN reported that she had reported those concerns several times to the nursing staff and management, but care had not improved. CNA NN reported that she had also found residents being double briefed on multiple occasions, which she had also reported to nursing staff. CNA NN reported that she had observed Resident #309 wearing double briefs on multiple occasions. CNA NN reported that it felt impossible to keep up with the care needs of the residents on the 300-hall, even when the facility was staffed at their usual staffing numbers. CNA NN reported that she did not feel like the nurses and nurse management had taken her concerns seriously regarding resident care. CNA NN reported that she hated seeing residents in these kinds of conditions and that Nobody should have to lay in a soiled brief that long. In an interview on 5/29/26 at 1:43 PM, CNA MM reported she had voiced concerns to facility management about night staff leaving residents wet and soiled for extended periods of time. CNA MM reported that the aides were not able to get to everyone right away in the morning, and she did not feel that first shift was staffed well enough for the aides to get to all residents in the morning to complete morning care timely. CNA MM reported that she had observed residents being double briefed by night shift, and even though she reported it to management, it continued to happen. CNA MM reported that Resident #309 was often found in soiled briefs. CNA MM reported that she recently had to Scrape bowel movement off of a resident's buttocks because it had been stuck on them for so long. CNA MM reported that she felt like the aides were doing everything they could to provide good care, and it was frustrating that management ignored concerns brought forth that could improve resident care. In an interview on 5/29/26 at 1:57 PM, LPN S reported she was the nurse assigned to care for Resident #309 that day. LPN S reported that she went to check on Resident #309 when he was yelling earlier that morning, that Resident #309 had told her that his aide told him she would be back after breakfast to help him, and he was still waiting for her. LPN S reported that she was unaware that Resident #309 had not received any care from staff that day until 12:06 PM. LPN S reported the acuity of the residents on the unit was very high; she had over 30 patients to pass medications and complete treatments for and she felt that she was not able to help the aides with resident care. LPN S reported the staff that worked on the rehab unit were supposed to come assist staff on the 300 hall, but they never did. Review of Resident #309's Advocate Rounding forms from 4/20/26 to 6/2/26 revealed, Open ended Questions: 1. Has staff been kind, courteous, and friendly? Resident stated no to this question 21 out of 24 times. 2. Do you feel safe with the care you are receiving here? Resident stated no to this question 8 out of 24 times. 3. Has your call light been answered timely since the last time you were asked? Resident stated no to this question 8 out of 24 times . Is room (Resident #309's room) free of odors? This was answered as no 23 out of 24 times . Is resident up and dressed? This was answered No 24 out of 24 times .Review of Resident #309's Call Log report log from 5/1/26 to 6/2/26 indicated that Resident #309's average to room elapsed time (time it takes for staff to enter resident room and turn off an activated call light) was 37:09. The highest to room elapsed time was 7:10:41. Noted 70 occasions where Resident #309's call light had (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been activated for over 30 minutes, 42 occasions where the call light was activated for over 1 hour, 15 occasions where the call light had been activated for more than 2 hours, 8 occasions where the call light was activated for over 3 hours, 4 occasions where the call light was activated for more than 4 hours, 3 occasions where the call light was activated for more than 5 hours and one occasion where the call light was activated for more than 7 hours. Review of the facility's Dignity policy last reviewed 2/3/26 revealed, Policy Overview: It is the policy of this facility that each resident will be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem. General Guidelines: Residents will be treated with dignity and respect at all times, the facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs . Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents, for example: helping the resident to keep urinary catheter bags covered, promptly responding to a resident's request for assistance . Staff are expected to treat cognitively impaired residents with dignity and sensitivity, for example: addressing the underlying motives or root causes for behavior .

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3026395.Based on interview and record review the facility failed to release medical records upon request for 1 (Resident #302) of 3 residents reviewed for access of resident records resulting in being unable to obtain and review requested records.Findings include:Review of Resident #302's (R#302) Census report, dated 1/14/26-4/18/26, indicated R#302 was admitted on [DATE] and discharged on 4/18/26.Review of R#302's Profile report, undated, indicated R#302's Family Member (FM) QQ was Emergency Contact #1.Responsible Party (bills).Guardian and FM RR was Emergency Contact #3.During an interview on 5/29/26 at 1:17 PM, Nursing Home Administrator (NHA) A confirmed FM QQ was R#302's guardian, Family Member QQ requested medical records for R#302 on 3/24/26 from DON B, those records were never provided to FM QQ, and the documents requested were not compiled to be able to be released until 4/14/26. NHA A reported R#302's FM RR, prior to 3/24/26, had come to the facility, obtained a medical record request, FM RR returned it the next day, and it had a signature from FM QQ. NHA A confirmed R#302's Family Lawyer (FL) OO had requested medical records for R#302 by postal mail, dated 4/9/26 and received date 4/14/26. NHA A reported the request was sent to the facility/company's legal team on 4/14/26 but they had not finished reviewing it yet. NHA A reported she contacted the legal team on 5/15/26 and 5/20/26 for an update but had not received a response back.Review of R#302's FL OO's medical record request, dated 4/9/26, stated, .April 9, 2026.VIA CERTIFIED MAIL.This firm represents (FM QQ) as guardian of (R#302).pressure wounds that developed while he (R#302) was a patient at your facility.Please note that (FM QQ) has previously requested the medical records of (R#302) from your facility, and we hereby demand that they be immediately produced and sent to my attention at [Contact information omitted], according to the request of his guardian.including any and all investigative reports, statements made by staff members, photos, videotapes and recordings, taken or made before, during and/or after his admission.Review of an email from NHA A, dated 6/2/26 at 1:08 PM, included the request from the surveyor for the medical record request FM RR submitted with FM QQ?s signature, and NHA A stated, The request was never scanned into the medical record so I'm unable to locate. During a follow up interview on 6/3/26 at 1:18 PM, NHA A reported she had misunderstood direction she received previously regarding release of records. NHA A reported she had thought their legal team had to approve the release of the records but confirmed the release of records can be done after review by NHA and regional clinical consultant. NHA A reported the requested records would be sent to R#302's FL OO today. Review of the facility's Release of Health Information policy, dated 5/1/2022, stated, .a patient or his or her authorized representative has the right to examine or obtain the patient's Health Record.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect for 1 (Resident #309) of 11 residents reviewed for abuse and neglect resulting in Resident #309 being left in a soiled brief for several hours, experiencing feelings of humiliation and dehumanization, and having his repeated verbal expressions for help go unanswered. Findings include: Resident #309Review of an admission Record revealed Resident #309 was originally admitted to the facility on [DATE] with pertinent diagnoses which included major depressive disorder, generalized anxiety disorder, muscle weakness, and debility (physical weakness as a result of illness). Review of a Minimum Data Set (MDS) assessment for Resident #309, with a reference date of 6/2/26 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #309 was moderately cognitively impaired. Review of Section GG: Functional Abilities revealed that Resident #309 required substantial/maximum assistance (resident requires more than half of the effort to complete an activity, and a helper (caregiver or staff) is doing the rest) with toileting. Review of Resident #309's Care Plan revealed, Focus: (Resident #309) is at risk for changes in behavior and mood r/t (related to) major depressive disorder . date initiated: 12/12/24. Interventions: Evaluate for physical needs; hunger, thirst, positioning, toileting, pain, cold/warm, etc Date initiated: 1/16/25 Focus: Alteration in elimination-incontinence of bladder and bowel r/t (related to) debility . Start date: 12/12/24. Interventions: Incontinence care per facility protocol. Date initiated: 12/12/24 .During an observation on 5/29/26 at 10:36 AM, this writer noted that the facility's call light board at the 300-hall nursing station indicated that Resident #309's call light was activated on at 8:51 AM. As this writer was looking at the call light board, Certified Nursing Assistant (CNA) R looked at the call light board and then went to Resident #309's room at 10:41 AM. At 10:43 AM, CNA R exited Resident #309's room. It was noted that Resident #309's call light had been turned off. During an observation on 5/29/26 at 10:43 AM, this writer entered Resident #309's room and noted a strong smell of urine. Resident #309 was lying in his bed in a soiled hospital gown, with a soiled brief, pad, and sheets. Resident #309 yelled out as this writer entered his room, I need to be changed! Resident #309 reported he turned his call light on to get help with being changed more than an hour prior to when CNA R entered his room. Resident #309 reported he was lying in a soiled brief, and that he had turned his call light on several times throughout the night and morning to get changed, but staff just turned off the light, said they would come back, but never did. Resident confirmed that he had asked CNA R to change him, and she said she would get his aide and be back, and then she left his room. Resident #309 voiced frustration about being left wet and soiled overnight. Resident #309 reported he felt embarrassed that he had to lay in soaked briefs, he felt like the staff did not care about him, and he was angry that the facility treated him so poorly. Resident #309 reported that it was common for the staff to ignore him all night and day because they don't like me or care. Review of Resident #309's toileting task on 5/29/26 at 10:50 AM indicated that staff had last documented incontinence care on 5/28/26 at 20:50 (8:50 PM). During an observation on 5/29/26 at 10:56 AM, CNA R returned to the 300 hall with 3 students that she was instructing to check on residents. CNA R went into the room next to Resident #309 and then two rooms across from Resident #309 to check in with the residents. CNA R then instructed the students to follow her to the other end of the hall to complete resident checks. Noted that CNA R did not enter Resident #309's room to complete a resident check. During an observation on 5/29/26 at 11:03 AM, Scheduler/CNA KK entered Resident #309's room and was overheard asking Resident #309 if she could complete her advocate rounds with Resident #309. Scheduler/CNA KK asked Resident #309 if staff had been kind, courteous and friendly? Resident #309 stated no. Scheduler/CNA KK then asked Resident #309 if his call light had been answered timely since the last time he was asked? Resident #309 stated no. Resident #309 was then overheard stating that he needed to be changed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Scheduler/CNA KK exited Resident #309's room after asking all of the advocate round questions. It was noted that she did not provide incontinence care to Resident #309. In an interview on 5/29/26 at 11:13 AM, Scheduler/CNA KK reported that Resident #309 did not report any care concerns to her. Scheduler/CNA KK reported that Resident #309 did not report that he needed assistance. During an observation 5/29/26 at 11:23 AM, Resident #309 began yelling out help! repeatedly. Each time Resident #309 yelled out for help, his tone got louder. Noted that this surveyor could hear Resident #309 yelling out for help at the opposite end of the hall. At 11:23 AM, CNA R returned to the 300 hall and went into another resident room and did not respond to Resident #309's calls for help. During an observation and interview on 5/29/26 at 11:24 AM, Licensed Practical Nurse (LPN) S entered Resident #309's room and then exited his room at 11:25 AM. As LPN S was exiting Resident #309's room, this writer queried as to what Resident #309 was yelling out for, and she reported He does this all the time, he will say he wants to be changed, but he won't even be wet, he has a lot of behaviors. When asked if LPN S checked Resident #309's brief to see if he was soiled, she stated that she did not check Resident #309's brief.During an observation and interview on 5/29/26 at 11:31 AM, Certified Nursing Assistant (CNA) NN entered Resident #309's room with care supplies and then exited his room at 11:33 AM. CNA NN reported that she went into Resident #309's room to set everything up so that she could provide care to Resident #309 when she was done providing care for another resident. During an observation on 5/29/26 at 11:52 AM, Resident #309's activated his call light. At 11:58 AM, This writer entered Resident #309's room and noted a new brief that was sitting on his tray table with an incontinence pad inside the brief. Resident #309 reported that he had been told by CNA NN she would return to change him as soon as she could. Resident #309 again reported feelings of humiliation and anger towards the facility staff for the way that they treated him. Resident #309 reported if he didn't yell out for help, that they would never come to help me. They don't like me, it makes me feel like crap. At 5/29/26 at 12:02 PM, This writer accompanied CNA NN entered Resident #309's room as she prepared to assist Resident #309 with incontinence care. CNA NN removed Resident #309's blanket from him and confirmed that Resident #309 was lying in a soiled brief. CNA NN stated to Resident #309 You definitely have not been changed since last night. Resident #309 again confirmed to this writer and CNA NN that he had not received care since the evening before. As CNA NN provided perineal care (peri care-is the hygienic cleaning and maintenance of the genital and anal areas to prevent infection, skin breakdown, and maintain comfort) to Resident #309, he reported a burning and itching on his buttocks area. CNA NN cleaned Resident #309's buttocks area and it was noted that Resident #309's skin looked red and irritated. In an interview on 5/29/26 at 1:34 PM, CNA NN confirmed that she was the staff member assigned to take care of Resident #309 that day, and that 12:02 PM was the first time that she had been in Resident #309's room to provide care to him. CNA NN reported that she was new to the unit, and that the residents on that hall required a lot of assistance, and she had been trying to catch up all morning. CNA NN reported that it was common for residents at the facility to go several hours without care, especially on nights. CNA NN reported that it was common for the night shift staff to not complete care on residents throughout the night, so she would often find residents wet and soiled in the morning. CNA NN reported that she had reported those concerns several times to the nursing staff and management, but care had not improved. CNA NN reported that she had also found residents being double briefed on multiple occasions, which she had also reported to nursing staff. CNA NN reported that she had observed Resident #309 wearing double briefs on multiple occasions. CNA NN reported that it felt impossible to keep up with the care needs of the residents on the 300-hall, even when the facility was staffed at their usual staffing numbers. CNA NN reported that she did not feel like the nurses and nurse management had taken her concerns seriously regarding resident care. CNA NN reported that she hated seeing residents in these kinds of conditions and that Nobody should have to lay in a soiled brief that long. In an interview on 5/29/26 at 1:43 PM, CNA MM reported she had voiced concerns to facility management about night staff leaving residents wet and soiled for extended periods of time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA MM reported that the aides were not able to get to everyone right away in the morning, and she did not feel that first shift was staffed well enough for the aides to get to all residents in the morning to complete morning care timely. CNA MM reported that she had observed residents being double briefed by night shift, and even though she reported it to management, it continued to happen. CNA MM reported that Resident #309 was often found in soiled briefs. CNA MM reported that she recently had to Scrape bowel movement off of a resident's buttocks because it had been stuck on them for so long. CNA MM reported that she felt like the aides were doing everything they could to provide good care, and it was frustrating that management ignored concerns brought forth that could improve resident care. In an interview on 5/29/26 at 1:57 PM, LPN S reported she was the nurse assigned to care for Resident #309 that day. LPN S reported that she went to check on Resident #309 when he was yelling earlier that morning, that Resident #309 had told her that his aide told him she would be back after breakfast to help him, and he was still waiting for her. LPN S reported that she was unaware that Resident #309 had not received any care from staff that day until 12:06 PM. LPN S reported the acuity of the residents on the unit was very high; she had over 30 patients to pass medications and complete treatments for and she felt that she was not able to help the aides with resident care. LPN S reported the staff that worked on the rehab unit were supposed to come assist staff on the 300 hall, but they never did. Review of Resident #309's Advocate Rounding forms from 4/20/26 to 6/2/26 revealed, Open ended Questions: 1. Has staff been kind, courteous, and friendly? Resident stated no to this question 21 out of 24 times. 2. Do you feel safe with the care you are receiving here? Resident stated no to this question 8 out of 24 times. 3. Has your call light been answered timely since the last time you were asked? Resident stated no to this question 8 out of 24 times . Is room (Resident #309's room) free of odors? This was answered as no 23 out of 24 times . Is resident up and dressed? This was answered No 24 out of 24 times .Review of Resident #309's Progress Note dated 5/29/26 at 3:02 PM and documented by LPN S revealed, Pt (patient) states that he was checked/changed at 0300 and his CNA checked him at shift change and at that time his brief was dry. Pt states he consumed more liquids this morning than usual and experienced heavy urination which caused his brief and padding to become saturated. Pt yelled out for staff to (sic) and turned his call light on. Nurse answered call light and Pt asked for his CNA. Nurse located CNA and she went to pt's room. Pt stated he needed to be changed, and she was able to provide cares shortly after. Soon after Pt turned his call on x2 and was checked and changed again . Noted that this progress note conflicts the interviews and observations completed by this writer on 5/29/26. Review of Resident #309's Progress Note dated 6/1/26 at 1:14 PM and documented by Regional Social Worker (RSW) PP revealed, Regional MSW (Masters Social Worker) approached resident after hearing him call out for help in his room. Upon entering room, resident was laying in bed with his call light in reach . Resident states that he was hoping to have an aide come down and help change him as well. RSW PP assisted Resident in hitting his call light and stopped at the nurse's station to report resident desire to have an aide check on him. Floor staff state that he has been yelling out for help frequently today and will send staff away upon entering his room., as well as him recently being checked on and being dry. Resident has a history of this behavior, and presentation is not atypical. Review of Resident #309's Call light log revealed that Resident #309's call light had been activated twice on 6/1/26 at 1:36 AM and 3:20 AM. Noted that Resident #309's call light log does not reflect that Resident #309's call light was activated around 1:14 PM as documented in RSW PPs progress note dated 6/1/26. Review of Resident #309's Toileting Task dated 6/1/26 revealed that staff had documented that Resident #309 was incontinent twice on 6/1/26 at 6:46 AM and 11:52 AM. Noted that Resident #309's toileting task did not reflect the report of staff frequently checking on Resident #309 throughout day as noted in RSW PP's progress note on 6/1/26. On 6/2/26 at 2:35 PM, this writer requested the facility's Abuse/Neglect policy. The facility did not provide the policy by survey exit.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review, the facility failed to implement policies and procedures of reporting an allegation of neglect in 1 (Resident #309) of 11 residents reviewed for abuse and neglect timely to the State Agency resulting in the allegation not being thoroughly investigated and the potential of further occurrences of neglect to continue. Findings include: Resident #309Review of a Minimum Data Set (MDS) assessment for Resident #309, with a reference date of 6/2/26 revealed Section GG: Functional Abilities revealed that Resident #309 required substantial/maximum assistance with toileting. During an observation on 5/29/26 at 10:36 AM, this writer noted that the facility's call light board at the 300-hall nursing station indicated that Resident #309's call light was activated on at 8:51 AM. As this writer was looking at the call light board, Certified Nursing Assistant (CNA) R looked at the call light board and then went to Resident #309's room at 10:41 AM. At 10:43 AM, CNA R exited Resident #309's room. It was noted that Resident #309's call light had been turned off. During an observation on 5/29/26 at 10:43 AM, this writer entered Resident #309's room and noted a strong smell of urine. Resident #309 was lying in his bed in a soiled hospital gown, with a soiled brief, pad, and sheets. Resident #309 yelled out as this writer entered his room, I need to be changed! Resident #309 reported he turned his call on to get help with being changed more than an hour prior to when CNA R entered his room. Resident #309 reported he was lying in a soiled brief, and that he had turned his call light on several times throughout the night and morning to get changed, but staff just turned off the light, said they would come back, but never did. Resident confirmed that he had asked CNA R to change him, and she said she would get his aide and be back, and then she left his room. Resident #309 voiced frustration about being left wet and soiled overnight. Resident #309 reported he felt embarrassed that he had to lay in soaked briefs, and he felt like the staff did not care about him, and he was so angry that the facility treated him so poorly. Resident #309 reported that it was common for the staff to ignore him all night and day because they don't like me or care. It was noted that Resident #309's call light was attached to his bed, and out of his hand. At 5/29/26 at 12:02 PM, This writer and CNA NN entered Resident #309's room to assist with incontinence care. CNA NN removed Resident #309's blanket from him and confirmed that Resident #309 was lying in a soiled brief. CNA NN stated to Resident #309 You definitely have not been changed since last night. Resident #309 again confirmed to this writer and CNA NN that he had not received care since the evening before. In an interview on 5/29/26 at 1:34 PM, CNA NN confirmed that she was the staff member assigned to take care of Resident #309 that day, and that 12:02 PM was the first time that she had been in Resident #309's room to provide care to him. CNA NN reported that she was new to the unit, and that the residents on that hall required a lot of assistance, and she had been trying to catch up all morning. CNA NN reported that it was common for residents at the facility to go several hours without care, especially on nights. CNA NN reported that it was common for the night shift staff to not complete care on residents throughout the night, so she would often find residents wet and soiled in the morning. CNA NN reported that she had reported those concerns several times to the nursing staff and management, but care had not improved. CNA NN reported that she had also found residents being double briefed on multiple occasions, which she had also reported to nursing staff. CNA NN reported that she had observed Resident #309 wearing double briefs on multiple occasions. CNA NN reported that it felt impossible to keep up with the care needs of the residents on the 300-hall, even when the facility was staffed at their usual staffing numbers. CNA NN reported that she did not feel like the nurses and nurse management had taken her concerns seriously regarding resident care. CNA NN reported that she hated seeing residents in these kinds of conditions and that Nobody should have to lay in a soiled brief that long. In an interview on 5/29/26 at 1:43 PM, CNA MM reported she had voiced concerns to facility management about night staff leaving residents wet and soiled for extended periods of time. CNA MM reported that the aides were not able to get to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	everyone right away in the morning, and she did not feel that first shift was staffed well enough for the aides to get to all residents in the morning to complete morning care timely. CNA MM reported that she had observed residents being double briefed by night shift, and even though she reported it to management, it continued to happen. CNA MM reported that Resident #309 was often found in soiled briefs. CNA MM reported that she recently had to Scrape bowel movement off of a resident's buttocks because it had been stuck on them for so long. CNA MM reported that she felt like the aides were doing everything they could to provide good care, and it was frustrating that management ignored concerns brought forth that could improve resident care. During an interview on 5/29/26 at 2:33 PM, this writer informed Nursing Home Administrator (NHA) A who was the designated abuse coordinator of the facility, of the concern that Resident #309 had not received incontinence care from 8:50 PM on 5/27/26 to 12:02 PM on 5/28.26.During an interview on 6/3/26 at 1:36 PM, Nursing NHA A reported that she did not report the allegation of neglect for Resident #309 to the State Agency because she looked into the concern and discovered that the staff caring for Resident #309 had not received adequate training, and that Resident #309 had reported that he was checked on at 3:00 AM on 5/27/26, so she did not think that concern reported was neglect. NHA A did not indicate why staffs' failure to provide care and services from the reported 3:00 am on 5/27/26 to 12:02 PM 5/28/26 occurred. On 6/2/26 at 2:35 PM, this writer requested the facility's Abuse/Neglect policy. The facility did not provide the policy by survey exit. For further information, please see F600.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review, the facility failed to identify and thoroughly investigate an allegation of neglect for 1 (Resident #309) of 11 residents reviewed for abuse and neglect resulting in an allegation of neglect going unaddressed and the potential for ongoing neglect due to an incomplete investigation. Findings include:Resident #309During an observation on 5/29/26 at 10:36 AM, this writer noted that the facility's call light board at the 300-hall nursing station indicated that Resident #309's call light was activated on at 8:51 AM. As this writer was looking at the call light board, Certified Nursing Assistant (CNA) R looked at the call light board and then went to Resident #309's room at 10:41 AM. At 10:43 AM, CNA R exited Resident #309's room. It was noted that Resident #309's call light had been turned off. During an observation on 5/29/26 at 10:43 AM, this writer entered Resident #309's room and noted a strong smell of urine. Resident #309 was lying in his bed in a soiled hospital gown, with a soiled brief, pad, and sheets. Resident #309 yelled out as this writer entered his room, I need to be changed! Resident #309 reported he turned his call on to get help with being changed more than an hour prior to when CNA R entered his room. Resident #309 reported he was lying in a soiled brief, and that he had turned his call light on several times throughout the night and morning to get changed, but staff just turned off the light, said they would come back, but never did. Resident confirmed that he had asked CNA R to change him, and she said she would get his aide and be back, and then she left his room. Resident #309 voiced frustration about being left wet and soiled overnight. Resident #309 reported he felt embarrassed that he had to lay in soaked briefs, and he felt like the staff did not care about him, and he was so angry that the facility treated him so poorly. Resident #309 reported that it was common for the staff to ignore him all night and day because they don't like me or care. It was noted that Resident #309's call light was attached to his bed, and out of his hand. At 5/29/26 at 12:02 PM, CNA NN entered Resident #309's room to assist with incontinence care. CNA NN removed Resident #309's blanket from him and confirmed that Resident #309 was lying in a soiled brief. Resident #309 again confirmed to this writer and CNA NN that he had not received care since the evening before. In an interview on 5/29/26 at 1:34 PM, CNA NN confirmed that she was the staff member assigned to take care of Resident #309 that day, and that 12:02 PM was the first time that she had been in Resident #309's room to provide care to him. CNA NN reported that it was common for the night shift staff to not complete care on residents throughout the night, so she would often find residents wet and soiled in the morning. CNA NN reported that she had reported those concerns several times to the nursing staff and management, but care had not improved. CNA NN reported that she had also found residents being double briefed on multiple occasions, which she had also reported to nursing staff. In an interview on 5/29/26 at 1:43 PM, CNA MM reported she had voiced concerns to facility management about night staff leaving residents wet and soiled for extended periods of time. CNA MM reported that she had observed residents being double briefed by night shift, and even though she reported it to management, it continued to happen. CNA MM reported that Resident #309 was often found in soiled briefs. CNA MM reported that she recently had to Scrape bowel movement off of a resident's buttocks because it had been stuck on them for so long. CNA MM reported that she felt like the aides were doing everything they could to provide good care, and it was frustrating that management ignored concerns brought forth that could improve resident care. During an interview on 5/29/26 at 2:33 PM, this writer informed Nursing Home Administrator (NHA) A who was the designated abuse coordinator of the facility, of the concern that Resident #309 had not received incontinence care from 8:50 PM on 5/27/26 to 12:02 PM on 5/28.26.During an interview on 6/3/26 at 1:36 PM, Nursing NHA A reported that the Assistant Director of Nursing (ADON) AA had looked into the concern. NHA A reported that Resident #309 had reported that he had been checked on at 3:00 AM, and that the staff caring for Resident #309 on 5/28/26 had not been trained, so she felt that ADON AA had addressed the concern. When this writer queried NHA A if she or ADON AA had any documentation to verify what they (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed for the investigation, NHA A reported that she would provide information for this writer to review. On 6/4/26 at 11:47 AM, NHA A provided a One on one in service record dated 5/30/26 that indicated that CNA NN had received a verbal review of Kardex (care plan sheet that aides use to follow resident care plans), every 2-hour checks, check all residents on rounds and report refusals. This was signed by ADON AA and CNA NN on 5/30/26. Noted that there was no further information to review and no indication or documentation of a thorough investigation per exhibit 369 in the State Operations Manual Appendix PP. On 6/2/26 at 2:35 PM, this writer requested the facility's Abuse/Neglect policy. The facility did not provide the policy by survey exit. For further information, please see F600.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3001998.Based on observation, interview, and record review the facility failed to initiate emergency medical services (EMS) and start cardiopulmonary resuscitation (CPR; an emergency lifesaving procedure performed when a person's heartbeat or breathing has stopped) timely for 1 (Resident #302) of 5 residents reviewed for life sustaining measures, resulting in an Immediate Jeopardy when, on [DATE], Resident #302 who was a full code, was found unresponsive and staff delayed EMS initiation for approximately 34 minutes and provided limited life sustaining measures were attempted by facility staff prior to EMS arrival. Resident #302 was pronounced dead on [DATE] by EMS personnel. This deficient practice is likely to cause serious harm, injury and/or death for the additional 51 of a total of 98 residents who have been deemed to have full code status. Findings include:The Immediate Jeopardy began on [DATE] when facility staff failed to call 911 and start/attempt life sustaining measures timely for Resident #302 (R#302) after being found unresponsive at 05:59 AM. Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on [DATE] at 2:40 PM. The surveyors confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at a scope of isolated and severity of actual harm due to not all staff having received training and sustained compliance has not been verified by the State Agency.Review of Resident #302's face sheet, dated [DATE], revealed R#302 was initially admitted to the facility on [DATE] and pertinent diagnoses of acute respiratory failure (the lungs are unable to get enough oxygen into the blood or can't remove carbon dioxide from the body adequately), congestive heart failure (progressive condition where the heart muscle is too weak/stiff to pump blood efficiently), apraxia (neurological motor disorder in which the brain struggles to coordinate and plan body movements), and cognitive communication deficit (impaired ability to speak, listen, read, write or socialize effectively).Review of R#302's physician order, dated [DATE], stated, Adv (Advanced) Directive (document outlining medical preferences during an emergency): Full code (indicated a desire for immediate CPR and life saving measures in the event one's heart or breathing stopped) Cardiopulmonary Resuscitation (CPR).Review of R#302's incident and accident report titled, #930 Unknown, dated [DATE] at 05:59 AM, stated, Resident: (R#302).Incident Location: Resident's Room.Incident Description.0559 (5:59 AM) resident (R#302) unresponsive to touch and voice, not breathing no pulse, CPR started/911 called, vital obtain no vital sign noted. EMT (emergency medical technician) arrival on unit 0606 (06:06 AM) took over CPR. EMT work on resident remain unresponsive/EMT pronounce resident dead 0710 (7:10 AM).Was this incident witnessed: N (No).Statements.Name.(Licensed Practical Nurse (LPN) C).Relation.Staff.Date.XXX[DATE].Statement.CNA (certified nurse aide; unidentified in the report) did rounds around 3:45 AM. I (LPN C) went in just before 0600 (06:00 AM) and found resident unresponsive, No respirations, no pulse. I verified code status, obtained crash cart, called code (code blue; medical emergency alert often indicating someone is experiencing cardiac arrest (heart stops) and/or respiratory arrest (breathing stops) requiring an immediate response), had staff (unidentified in the report) call 911, and began CPR. We were unable to revive him and EMS showed up and took over.Agencies / People Notified.Director of Nursing (DON B) [DATE] 06:11 (6:11 AM).Review of Emergency Medical Services/ambulance Prehospital Care Report Summary (an EMS run sheet; legal and medical document used by EMS to record every detail of a 911 call or medical transport), dated [DATE], stated, Call Received: 06:34:08 (AM).En Route: 06:34:52 (AM).On Scene: 06:38:22.Patient (R#302) Contact: 06:42:22 (AM).Dead After Arrival - Patient Dead at Scene-Resuscitation Attempted (Without Transport).Other Responding Agencies: (city name omitted) FD (Fire Department).Dispatch Reason.Cardiac or Respiratory Arrest/Death.Chief Complaint.Cardiac Arrest.06:43:22 (AM).Treatment-CPR.06:45:22 (AM).Treatment- BVM Ventilation (Bag-valve-mask; an emergency technique used to (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provide positive-pressure ventilation to patients who are not breathing or breathing inadequately).07:10:30 (AM).Termination of resuscitation.Was an AED (portable, electronic medical device designed to treat people experiencing sudden cardiac arrest) applied prior to EMS arrival: No.Estimated Time of Arrest: 06:00:00 (AM) - Approximate.Time of First CPR: 06:34:00 (AM).End of Event: Expired (died) in the Field.Narrative History Text:. FD was not performing compressions at that time.Pt (patient; R#302) was pulseless (no detectable pulse) and apneic (state of having stopped breathing) . Staff reported that Pt was at baseline ability and mentation at 5:59 (AM) when she did her rounds.EMS noted Pt was warm to the touch. EMS started compressions. Pt was in asystole (the complete stopping of the heart's electrical and pumping activity). PT LAST SEEN AT AND BY: (Staff) at 5:59AM this morning .Additional Assessment Notes.FD was getting good compliance with BVM.Pt was in asystole for the entirety of care.ETCO2 (end-tidal carbon dioxide; maximum carbon dioxide exhaled at the end of a breath) was at 0 for the entirety of arrest. After 20 minutes of resuscitation attempts with no changes, EMS called [Hospital Name omitted] ER (emergency room) for cease resuscitation orders.Review of the Fire Department's Detailed EMS Report, dated [DATE], stated, Incident information.Dispatch Reason: Cardiac Arrest / Death. Cardiac Arrest: Yes, Prior to EMS Arrival.Final Patient Acuity: Dead.XXX[DATE] 06:40:00 (AM) Arrived at Patient.XXX[DATE] 06:41:30 (AM) CPR.Review of the Fire Department's [NAME] (National Emergency Response Information System) Print Report, dated [DATE], stated, Initial Details.Fire Dispatch: [DATE] 06:32:52 (AM).On Scene 06:37:17 (AM).Engine (fire engine/truck) 4 and [EMS Company Name] pulling in just prior to 12's (Engine 12).Staff was delayed opening the side door for us; main entrance was oos (out of service) due to construction.During a telephone interview on [DATE] at 11:20 AM, LPN M reported when she arrived at R#302's room the morning of [DATE], LPN C and Registered Nurse (RN) I were in the room with R#302 but neither nurse had hands on the resident and were not performing CPR. LPN M reported she began CPR at that point because nobody was and stopped after a few minutes and LPN C took over CPR. LPN M reported she had received a call from DON B that staff may need help, so she ran over to assist. LPN M reported she couldn't remember what time she entered R#302's room and started CPR but reported as she left R#302's room EMS were coming into the building. LPN M reported she didn't know if anything from the crash cart (a specialized mobile cart used in medical facilities that contains lifesaving emergency equipment to treat cardiac and/or respiratory arrest allowing rapid response) was used and was focused on starting CPR.Review of R#302's [DATE] incident witness statement from LPN M, dated [DATE], stated, .Coming upon the door (R#302's room), the crash cart was sitting in the hallway right outside the resident's door. When I entered, I saw (LPN C) standing on the side of the bed near the window and RN I was standing over (R#302). No CPR was being performed.EMS was just entering the building to head to (R#302)'s room.During a telephone interview on [DATE] at 2:36 PM, LPN C reported she couldn't recall all the details of R#302's [DATE] code blue event but indicated she had made a detailed report to management and the incident report included what happened. LPN C recalled RN I had come to assist her within a minute or two of having started CPR on R#302. LPN C alleged to have started CPR after determining the code status (full code) and then yelled out for someone to call 911. LPN C reported she couldn't remember who came and called 911. LPN C reported LPN M also entered the room at one point and alleged herself, LPN C, and RN I alternated performing CPR until the fire department arrived at which point they took over.During a follow up telephone interview on [DATE] at 8:39 AM, LPN C reported she couldn't explain how the EMT arrived on [DATE] at 6:06 AM, as she had stated in the incident report, and the EMS run sheet indicated the 911 call was received at 6:34 AM. LPN C reported she had started CPR, yelled out for help, and RN I brought the crash cart. LPN C reported she couldn't remember if oxygen was administered to R#302 from the crash cart by staff. LPN C stated, Whatever I put in my note I did, when asked if a BVM was used. LPN C reported she would not answer the question of how she performed CPR. Before the surveyor could ask questions about the use of the crash cart's equipment/supplies, such as oxygen, BVM, or an AED, LPN C became audibly upset and (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hung up the phone.Review of R#302's progress note, dated [DATE] at 8:02 AM and written by LPN C, provided no additional details, times, or information and was the same as what was entered in the Nursing Description on R#302's incident report titled #930 Unknown.During a telephone interview on [DATE] at 9:13 AM, RN I confirmed she couldn't remember if any oxygen, BVM, or an AED was used during R#302's [DATE] code blue incident and couldn't recall any specific times. RN I indicated EMS arrived quickly and she and LPN C alternated performing CPR for a short time before EMS arrived.During an observation on [DATE] at 9:30 AM, the 300-hall crash cart was covered in a pile of clothes and dust. On the cart was a binder that had a nightly crash cart checklist for staff to review to ensure that the cart was stocked and equipment was working in the event of an emergency. April and [DATE]'s nightly crash cart log were completed on 9 of 30 days for the month of April and 12 of 27 elapsed days for the month of [DATE]. There was an unopened full oxygen tank attached to the cart with a tag attached to the tank dated [DATE] (full prior to R#302 code blue event). Review of R#302's Census report, dated [DATE]-[DATE], indicated R#302 had resided on the 300s hall for the duration of his stay at the facility.During an interview on [DATE] at 9:40 AM, Director of Nursing (DON) B reported she was not aware of how often staff were supposed to check the crash cart at the facility. DON B reviewed the nightly crash cart log and confirmed that staff were supposed to be completing the list every night per the instructions on the log. DON B confirmed the facility had missed checking the crash cart nightly. DON B reported the 300-hall crash cart was the cart that was used on [DATE] when R#302 was found unresponsive. DON B confirmed the 300-hall crash cart oxygen tank dated [DATE] had not been opened and therefore couldn't have been used on R#302 on [DATE]. DON B reported on [DATE] around 6:10 AM, she had received a call from LPN C. DON B reported that LPN C had told her that she had just found R#302 unresponsive and that he was a full code. DON B reported that she told LPN C to begin CPR on R#302, that LPN C then ended the call, then called her right back, and told her that she was going to get RN I for help. DON B confirmed that LPN C had not yet initiated CPR on R#302, and left R#302 in his room alone to go find RN I for assistance. DON B confirmed that she did not know if LPN C or anyone else in the facility had called 911 yet, and uncertain the amount of help RN I would be to LPN C, so she called LPN M and asked her to go assist LPN C. DON B confirmed that LPN C had left R#302 in his room with CNA J to go get assistance from RN I. DON B was unable to report which staff member called a code blue in the facility, which staff member called 911, if any staff members placed a board (CPR backboard; hard and flat device placed under the back to provide a solid surface necessary for effective chest compressions during CPR) under R#302 prior to allegedly beginning compressions on R#302, and/or if facility staff used an automated external defibrillator (AED). During an interview on [DATE] at 11:51 AM, LPN S reported that she arrived at the facility around 6:40 AM on [DATE] when she saw that EMS workers were in R#302's room working on him. LPN S reported that there was not a crash cart outside of R#302's room and there was no facility staff in R#302's room. LPN S reported that during shift change report, LPN C reported to her that she didn't do CPR on R#302 because she didn't know that he was a full code.Review of R#302's [DATE] incident witness statement from CNA J, dated [DATE], stated, I was on the group with R#302 on [DATE] into AM (morning) of [DATE].found him on my last round he didn't look right I was not sure if he was breathing, he never responses (sic) but he looked off to me. I went to find (LPN C) to report this and have her go back with me to check him out.I'm not sure of the exact times I was doing my last round, and it had to be very close to 6a (6:00 AM) and when we went back it was a little after. (LPN C) indicated she (sic) he (R#302) had passed. I heard someone call Code Blue, not sure who it was. (LPN C) went and got the other nurse, (RN I) to assist. Review of the facility's Cardiac Arrest Emergency Management (MICHIGAN) policy, review date [DATE], stated, .CPR is to be initiated on residents in the event of a cardiac arrest.Only EMS Personnel or a physician/practitioner can make the decision to stop CPR once it has been started.Guidelines for a resident with a full code order:.For those residents where CPR was initiated by Facility staff, 911 shall be contacted for continuation of emergency care.First person to identify (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	emergency with resident calls for assistance.Do not leave the resident unless an immediate response is anticipated.First licensed nurse to arrive:.Directs additional staff to review the resident's medical record for the resident's code status and whether there is a Do Not Resuscitate Order in place.If the resident has a Full Code order and is without a pulse/respirations:.Begin CPR.Direct designated staff to page Code Blue to location of need.Direct designated staff to call 911 requesting emergency assistance.Staff nearest the crash cart transports it and the AED (if applicable) to the location and assists with the following:.Opens the crash cart.Sets up any needed equipment per licensed nurse instruction (i.e. Oxygen, AED, etc.).Turn on the AED as soon as it arrives to bedside and follow the prompts.After EMS services arrive and take over the resident's care, the licensed nurse should document the following in a progress note:.Occurrence and time of code called.Time EMS contacted.Step by step description of care provided: initiation of CPR, AED use (if applicable), oxygen administration.EMS arrival and transfer of care.any additional applicable information.The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy. The steps the facility took to remove the immediacy were as follows:1. The Facility's interdisciplinary Team reviewed the facility's Cardiac Emergency Policy and Advance Directive Policy on [DATE]. The policies were reviewed in detail/ accepted/and reinforced for immediate implementation.2. The Administrator and Regional Social Services Director completed an audit of all residents currently in-house to confirm code statuses are accurate on [DATE].3. The Director of Nursing and/or Designee initiated mandatory education for all licensed nurses beginning [DATE]. Education includes:- Review of the Facility's Cardiac Arrest Emergency Management Policy/including requirements for immediate initiation of CPR for residents identified as Full Code and requirements for immediate notification of emergency medical services during cardiac or respiratory emergencies/and- Review of the Facility's Advance Directive-Code Status Policy, including where to locate a resident's Code Status.- Director of Nursing and/or Designee will utilize a CPR quiz for licensed nurses to ensure that previous education has been retained. Director of Nursing and/or Designee will quiz random licensed nurses 5 times per week; any incorrect answers will be given further one-to-one education. As highlighted in the CPR quiz/crash carts must be checked nightly on 3rd shift (overnight shift). Assistant Director of Nursing and/or designee will audit crash cart signature log daily to identify any discrepancies. One-to-one education will be provided to any nurse found not to have audited the crash cart.- The education will be more interactive and competency-focused. The Director of Nursing and/or designee will conduct spontaneous/ scenario-based checks by approaching licensed nurses at random and asking/ What would you do in situation X? (X meaning; different scenarios the facility would present to staff)? This real-time questioning ensures that staff can apply CPR knowledge in practical situations, not Just in a classroom setting. Any incorrect or incomplete responses will be immediately followed by one-to-one coaching to reinforce correct actions and ensure sustained competency.4. The Director of Nursing and/or Designee initiated mandatory education for all Certified Nursing Assistants (C.N.A.s) beginning [DATE]. Education includes:- Review of the Facility's Cardiac Arrest Emergency Management Policy/ specifically highlighting; The first person to identify a resident emergency should call for assistance, not leaving the resident unattended after an emergency has been identified, and any staff member can call 911 in the event of a resident emergency.- How to utilize the Cardiac-Respiratory Arrest form- No licensed nursing staff member will be permitted to work in the facility until required education has been completed/ as validated by the Director of Nursing and/or designee. The Administrator and/or designee will maintain documentation of completed education for all licensed nursing staff.5. The facility will conduct ongoing audits to ensure compliance with emergency response procedures, including verification of code status awareness and adherence to CPR initiation protocols.6. Mock drills started [DATE], and will be conducted at minimum, weekly per shift, and will continue until compliance is established through the Facility's QAPI (Quality Assurance and Performance Improvement) Committee. Director of Nursing and/or Designee will review the facility's (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cardiac-Respiratory Arrest Documentation form (attached) (attached meaning; the facility provided with the verified removal plan) during every mock de-briefing. Forms will then be passed through QAPI to identify any additional barriers.7. Facility ordered 3-D (three dimensional) AED signs that will be placed on the hallways on [DATE]. These signs will give directions as to where the AED is located on the hallway.8. Facility placed clipboards on all crash carts that contain the Cardiac Arrest Documentation form to help promote accurate documentation timelines.9. Facility filed formal complaints with [NAME] (Licensing and Regulatory Affairs; A department within the State of Michigan) regarding the licenses of (RN I) and (LPN C).According to the Fundamentals of Nursing ([NAME] and [NAME], 6th ed., 2005), Cardiac arrest is characterized by an absence of pulse and respiration. If the nurse determines that the client has had a cardiac arrest, cardiopulmonary resuscitation (CPR) must be initiated. CPR is a basic emergency procedure of artificial respirations and manual external cardiac massage.Per the American Red Cross First Aid and Safety Handbook (2011), A person in cardiac arrest is unconscious, not breathing, and has no heartbeat. The Handbook revealed that a person in cardiac arrest will have the greatest chance of survival if there is: 1). Early access to the emergency medical services (EMS) system, 2). Early CPR, 3). Early defibrillation, and 4). Early advanced medical care. The Handbook also revealed that without early CPR and defibrillation, the chance for survival is greatly reduced. According to the Handbook, once you begin CPR, do not stop except in one of these situations.another trained responder or EMS personnel take over.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate staffing to promote the physical, mental, and psychosocial well-being in 2 of 13 residents (Resident #306 and Resident #309) reviewed for staffing, resulting in unmet care needs and the potential for physical and psychosocial harm for all residents in the facility. Findings include: Resident #306Review of an admission Record revealed Resident #306 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression, muscle weakness, and repeated falls. Review of a Minimum Data Set (MDS) assessment for Resident #306, with a reference date of 4/17/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #306 was cognitively intact. In an observation and interview on 5/27/26 at 10:01 AM, Resident #306 was lying in her bed talking to this writer and Wound Care Licensed Practical Nurse (WCLPN) T. Resident #306 reported feeling frustrated with the care that she received at the facility. Resident #306 reported that staff at the facility would frequently ignore her call light when she would activate it to ask for help with care, or they would enter her room and turn off her call light before addressing her needs. Resident #306 reported that most of the staff at the facility seemed stressed and burned out, and that they were always running late with cares. During an observation on 5/29/26 at 8:33 AM, This writer noted that Resident #306's call light had been activated since 7:46 AM (47 minutes). It was also noted that there were 4 other call lights activated on the same hall as Resident #306. In an observation and interview on 5/29/26 at 8:55 AM, Resident #306 confirmed that her call light had been activated for assistance since 7:46 AM. Resident #306 reported it was common for her to have to wait for over an hour for her call light to be answered. Resident #306 voiced frustration regarding the long call light wait times, and reported feeling like the staff just could care less about what we (residents at the facility) need. They make me feel like I am bothering them every time I ask for help. On 5/29/26 at 9:00 AM, Certified Nursing Assistant (CNA) R entered Resident #306's room and turned off her call light. Noted that Resident #306's call light had been activated (1 hour and 27 minutes after Resident #306 activated her call light). Resident #309Review of an admission Record revealed Resident #309 was originally admitted to the facility on [DATE] with pertinent diagnoses which included major depressive disorder, generalized anxiety disorder, muscle weakness, and debility (physical weakness as a result of illness). Review of a Minimum Data Set (MDS) assessment for Resident #309, with a reference date of 6/2/26 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #309 was moderately cognitively impaired. Review of Section GG: Functional Abilities revealed that Resident #309 required substantial/maximum assistance (resident requires more than half of the effort to complete an activity, and a helper (caregiver or staff) is doing the rest) with toileting. Review of Resident #309's Care Plan revealed, Focus: (Resident #309) is at risk for changes in behavior and mood r/t (related to) major depressive disorder . date initiated: 12/12/24. Interventions: Evaluate for physical needs; hunger, thirst, positioning, toileting, pain, cold/warm, etc Date initiated: 1/16/25 Focus: Alteration in elimination-incontinence of bladder and bowel r/t (related to) debility . Start date: 12/12/24. Interventions: Incontinence care per facility protocol. Date initiated: 12/12/24 .During an observation on 5/29/26 at 10:36 AM, this writer noted that the facility's call light board at the 300-hall nursing station indicated that Resident #309's call light was activated at 8:51 AM. As this writer was looking at the call light board, Certified Nursing Assistant (CNA) R looked at the call light board and then went to Resident #309's room at 10:41 AM. At 10:43 AM, CNA R exited Resident #309's room. It was noted that Resident #309's call light had been turned off. During an interview on 5/29/256 at 10:40 AM: Licensed Practical Nurse (LPN) S reported that the unit was not working short staffed that day. LPN S reported that the facility used to staff three nurses on the 300 and 400 hall, and they would typically have 5 aides between the 300 and 400 hall. LPN S reported that (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the residents on the 300-hall were very high acuity, and it was common for the aides to struggle to keep up with resident care. LPN S reported that the nurses on the 300 and 400 hall each had over 30 residents, so they were usually also running behind and not able to assist the CNA's with resident care. During an observation on 5/29/26 at 10:43 AM, this writer entered Resident #309's room and noted a strong smell of urine. Resident #309 was lying in his bed in a soiled gown and brief, with a soiled pad and sheet under him. Resident #309 reported he turned his call light on to get help with being changed more than an hour prior to when CNA R entered his room. Resident #309 reported he was lying in a soiled brief, and that he had turned his call light on several times throughout the night and morning to get changed, but staff just turned off the light, said they would come back, but never did. Resident confirmed that he had asked CNA R to change him, and she said she would get his aide and be back, and then she left his room. Resident #309 reported that it was common for the staff to ignore him all night and day because they don't like me or care. Review of Resident #309's toileting task on 5/29/26 at 10:50 AM indicated that staff had last documented incontinence care on 5/28/26 at 20:50 (8:50 PM). At 5/29/26 at 12:02 PM, This writer and CNA NN entered Resident #309's room to assist with incontinence care. CNA NN removed Resident #309's blanket from him and confirmed that Resident #309 was lying in a soiled brief. CNA NN stated to Resident #309 You definitely have not been changed since last night. Resident #309 again confirmed to this writer and CNA NN that he had not received care since the evening before. In an interview on 5/29/26 at 1:34 PM, CNA NN confirmed that she was the staff member assigned to take care of Resident #309 that day, and that 12:02 PM was the first time that she had been in Resident #309's room to provide care to him. CNA NN reported that she was new to the unit, and that the residents on that hall required a lot of assistance, and she had been trying to catch up all morning. CNA NN reported that it was common for residents at the facility to go several hours without care, especially on nights. CNA NN reported that it felt impossible to keep up with the care needs of the residents on the 300-hall, even when the facility was staffed at their usual staffing numbers. CNA NN reported that she did not feel like the nurses and nurse management had taken her concerns seriously regarding resident care. CNA NN reported that she was new to the facility, but already feeling burned out because she did not feel like staff were able to meet the residents' basic care needs. In an interview on 5/29/26 at 1:43 PM, CNA MM reported she had voiced concerns to facility management about night staff leaving residents wet and soiled for extended periods of time. CNA MM reported that the aides were not able to get to everyone right away in the morning, and she did not feel that first shift was staffed well enough for the aides to get to all residents in the morning to complete morning care timely. CNA MM reported that she felt like the aides were doing everything they could to provide good care, and it was frustrating that management ignored concerns brought forth that could improve resident care. CNA MM reported that the 300-hall had several residents that required two staff members for cares, high fall risks, behaviors, and assistance with eating, so there was hardly any time to get any other care done. CNA MM reported that residents were frequently missing care because the staff were not able to get to all of the residents on the unit during their shifts. CNA MM Reported that the facility typically staffed 4-5 CNA's on the 300 and 400 halls (The Coast Unit.)In an interview on 5/29/26 at 1:57 PM, LPN S reported she was the nurse assigned to care for Resident #309 that day. LPN S reported the acuity of the residents on the unit was very high; she had over 30 patients to pass medications and complete treatments for and she felt that she was not able to help the aides with resident care. LPN S reported that the nurses and aides on the 300 and 400 halls were always running behind because the resident acuity of those units was not manageable with the number of staff that they had. LPN S reported that residents were frequently getting their medications and treatments late, if at all. LPN S reported the facility used to staff 3 nurses between the 300 and 400 hall, but they recently dropped down to two nurses. Review of Resident #309's Advocate Rounding forms from 4/20/26 to 6/2/26 revealed, 2. Do you feel safe with the care you are receiving here? Resident stated no to this question 8 out of 24 times. 3. Has your call light been answered timely since the last time you were asked? Resident stated no to (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	this question 8 out of 24 times . Is room (Resident #309's room) free of odors? This was answered as no 23 out of 24 times . Is resident up and dressed? This was answered No 24 out of 24 times .Review of Resident #309's Call Log report log from 5/1/26 to 6/2/26 indicated that Resident #309's average to room elapsed time (time it takes for staff to enter resident room and turn off an activated call light) was 37:09. The highest to room elapsed time was 7:10:41. Noted 70 occasions where Resident #309's call light had been activated for over 30 minutes, 42 occasions where the call light was activated for over 1 hour, 15 occasions where the call light had been activated for more than 2 hours, 8 occasions where the call light was activated for over 3 hours, 4 occasions where the call light was activated for more than 4 hours, 3 occasions where the call light was activated for more than 5 hours and one occasion where the call light was activated for more than 7 hours. During an interview on 6/2/26 at 4:16 PM, Registered Nurse (RN) FF reported that staffing at the facility had been an ongoing concern for her. RN FF reported that she had worked the night before and had almost 30 residents to care for, and she was running behind most of the night. RN FF reported that the nighttime medication pass for the 300 hall was very heavy, and it was a challenge to get medications and treatments administered timely. RN FF reported that the facility often had to work short staffed, and that they had recently only had two CNAs on the 300 and 400 halls for an entire night shift. During an interview on 6/2/26 at 10:47 AM, LPN BB reported that he would not comment on staffing at the facility because I feel like every time I have voiced concerns it just comes back on me and the facility never does anything to improve the staffing and nothing comes of it, so I will just say that the facility had told us they are meeting state staffing requirements, and that is good enough. You can see how the resident care is from being there. LPN BB then reported that when he voiced staffing concerns before, facility management had said that they should be fine because they have the 100 hall staff members to help them, but they never come to the 300 and 400 to hall to help. Review of the Facility's Facility Assessment last reviewed on 5/29/26 revealed, . Staffing guidelines: The facility's staffing is based on resident population and acuity. The following generally represents the daily staffing at the facility utilizing the number of employees: . Nursing Assistants (23-33.5), Licensed Nurses (10-12.5). Noted that the next page of the facility assessment included a typical daily schedule of 2 nurses on the bay unit, 2 nurses in the harbor unit, and 2 nurses on the coast unit in a 24-hour period. CNA's: The bay 1-2 each shift, The Harbor: 3 each shift, and the Coast: 5-6 each shift. Noted this conflicted with the previous page which noted the typical staffing guidelines included 10-12.5 nurses in a 24-hour period- but the typical schedule reflected 8 nurses and 23-33.5 CNAs in a 24-hour period- but the typical schedule reflected 22 CNAs. It was noted that the facility assessment had based their staffing off an average of 91 residents, but the census at survey entrance was 98. For further information, see F600 and F550.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to properly secure medications in two of five medication carts resulting in the potential for the compromise of medications, accidental indigestion, and/or misappropriation of medications. Findings include:During an observation on 5/29/26 at 6:33 AM, a medication cup containing 4 loose pills was sitting on top of the 100-hall medication cart which was unlocked and sitting next to the nurses' station. No staff were present near the nurses' station, in the 100-hall, nor within sight of the 100-hall medication cart.During an interview 5/28/26 at 8:04 AM, Licensed Practical Nurse (LPN) F confirmed she was assigned to the 100-hall, and that she had not locked her medication cart when she went to assess a resident in their room. LPN F was unable to report why she had left the medications on top of the unlocked cart unsupervised, and reported that she had a busy night and was working over because a staff member had called in. During an observation on 5/29/26 at 10:32 AM, The 300-hall medication was observed unlocked without a nurse in view of the cart.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate medical records for 6 (Resident #301, #306, #309 #311, #312 and #313) residents out of a total of 13 residents reviewed for complete and accurate medical record documentation, resulting in the potential for staff and providers mismanaging care for residents. Findings include: Resident #301 Review of an admission Record revealed Resident #301 was originally admitted to the facility on [DATE] with pertinent diagnoses which included adult failure to thrive (syndrome of progressive decline in weight, physical function, nutrition, and cognitive or psychosocial health, often seen in older adults), muscle weakness, and parkinsons disease (neurological disorder that affects movement.) Review of Resident #301's Treatment Administration Record (TAR) for May 2026 revealed, Order: Enteral Feed (Delivery of nutrition directly though the gastrointestinal tract for those that cannot eat by mouth) one time a day via G- tube free water flushes . start date: 5/26/26. Noted missing documentation to indicate if the treatment was completed on the following date: 5/26/26. Review of Resident #301's Medication Administration Record (MAR) for May 2026 revealed, Order: Fluad Quadrivalent (Influenza vaccine) . inject 0.5 ml (milliliters) intramuscularly everyday shift for 1 day . start date: 5/29/26. Noted missing documentation to indicate if the vaccine was administered on the following date: 5/29/26. Review of Resident #301's MAR for May 2026 revealed, Order: Vital signs every shift x3 days and then daily every shift for monitoring. Start date: 5/26/26. Noted missing documentation to indicate if the treatment was completed on the following date: 5/29/26. Review of Resident #301's MAR for May 2026 revealed, Order: Ammonium lactate 12% lotion. Apply to bilateral legs (both legs) topically every shift for dry skin. Start date:5/12/26. Noted missing documentation to indicate if the treatment was completed on the following date: 5/29/26. Review of Resident #301's TAR for May 2026 revealed, Order: Monitor for signs and symptoms of anaphylaxis (severe allergic reaction that can be life threatening), temp, chills, fever, muscle aches/pains, check injection site for edema and redness and notify Dr. (Doctor) of any abnormalities. Please indicate yes or no every shift for vaccine administration for 3 days. Start date: 5/29/26. Noted missing documentation to indicate if the treatment was completed on the following date: 5/30/26. Review of Resident #301's MAR for May 2026 revealed, Order: Carbidopa Levodopa (medication primarily used to treat parkinson's disease symptoms) Oral tablet 20-100 MG (milligrams). Give 2 tablets via G-tube every 6 hours for parkinsons. Start date: 5/25/26. Noted missing documentation to indicate if the medication was administered on the following date: 5/29/26. Review of Resident #301's MAR for May 2026 revealed, Order: Nystatin Suspension (antifungal medications used to treat yeast infections) Give 5 ml by mouth four times a day for oral thrush (fungal infection) for 14 days . start date: 5/26/26. Noted missing documentation to indicate if the medication was administered on the following dates: 5/29/26. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #301's TAR for May 2026 revealed, Order: Suprapubic, foley, or condom (types of catheters) catheter output amount every shift. Start date: 5/28/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/28/26, 5/29/26, and 5/20/26. Review of Resident #301's TAR for May 2026 revealed, Order: Wound care: Cleanse affected area on sacrum (area of lower back) with generic wound cleanser . start date: 5/27/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/29/26. Resident #306 Review of an admission Record revealed Resident #306 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #306, with a reference date of 4/17/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #306 was cognitively intact. During an interview on 5/27/26 at 3:52 PM, Resident #306 reported concerns with nursing staff missing medications and treatments. Resident #306 reported that she felt like the nurses were inconsistent in medications and treatments that were ordered for her, and she felt like she was not always getting all of her medications and treatments. Review of Resident #306's MAR for May 2026 revealed, Order: Levothyroxine (hormone replacement medication) oral tablet. 100 mg. Give 1 tablet by mouth one time a day for hypothyroidism (condition where the thyroid does not produce enough thyroid hormones) . start date: 4/8/26. Noted that missing documentation to indicate if medication was administered on the following dates: 5/18/26, and 5/26/26. Review of Resident #306's MAR for May 2026 revealed, Order: House liquid protein (medical grade protein supplement designed for rapid absorption and highˆdensity nutritional support) three times a day. Start date: 4/13/26. Noted missing documentation to indicate if the medication was administered on the following dates: 5/26/26. Review of Resident #306's MAR for May 2026 revealed, Check blood sugar before meals and at HS (At bedtime) for DM 11 (Diabetes Mellitus Type 2). Start date: 4/8/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/18/26, 5/24/26, and 5/26/26. Review of Resident #306's TAR for May 2026 revealed, Order: Ensure abdominal dressing placement Q (every) shift. Change per order if not in place two times a day for abdominal wound. Start date: 4/8/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/18/26, 5/20/26, 5/22/26, 5/25/26 and 5/29/26. Review of Resident #306's TAR for May 2026 revealed, Order: Menthol (Topical Analgesic) external gel 5%. Apply to knees bilaterally topically two times a day for pain. Order: 5/20/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/20/26, 5/21/26, 5/22/26, 5/25/26, 5/26/26, 5/27/26, and 5/30/26. Review of Resident #306's TAR for May 2026 revealed, Order: Wound care: Irrigate RLQ (right lower quadrant) abdominal wound with saline and pat dry . two times a day for wound care. Start date: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/19/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/22/26 and 5/26/26. Review of Resident #306's TAR for May 2026 revealed, Order: Wash with soap and water, rinse, pat dry bilateral inner thighs and labia every shift for red blanchable (sic) until healed. Start date: 4/16/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/18/26, 5/20/26, 5/22/26, 5/25/26, and 5/26/26. Resident #309 Review of an admission Record revealed Resident #309 was originally admitted to the facility on [DATE] with pertinent diagnoses which included major depressive disorder, generalized anxiety disorder, and muscle weakness. Review of Resident #309's TAR for May 2026 revealed, Order: Ammonium Lactate External Lotion 12%. Apply to feet/heels topically every day for dry skin. Start date: 2/28/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/18/26, 5/19/26. Review of Resident #309's TAR for My 2026 revealed, Order: Orthosis (external medical device used to correct alignment or provide support)/splint to be applied to: Left resting hand splint on for 8 hours as tolerated. Perform skin assessment upon removal. Every morning and at bedtime. On in the evening, off in the morning. Start date: 11/20/25. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/18/26. Resident #311 Review of an admission Record revealed Resident #311 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcer of right heel and muscle weakness. Review of Resident #311's TAR for May 2026 revealed, Order: Check placement of wound dressing on right heel. If soiled/missing perform wound care two times a day for wound care. Start date: 2/13/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/18/26 and 5/25/26. Review of Resident #311's TAR for May 2026 revealed, Order: Foam heel suspension boots to be worn at all times as tolerated every shift for PI (pressure injury). Start date: 11/20/25. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/18/26. Review of Resident #311's TAR for May 2026 revealed, Order: Place alternating pressure mattress on bed for pressure reduction. Monitor alternating pressure mattress function and check that the settings are appropriate for the patient every shift . Start date: 11/20/25. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/18/26. Resident #312 Review of an admission Record revealed Resident #312 was originally admitted to the facility on [DATE] with pertinent diagnoses which included major depressive disorder and repeated falls. Review of Resident #312's MAR for May 2026 revealed, Order: Aquaphor external Ointment. Apply to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feet topically one time a day for diabetic neuropathy (complication of diabetes, characterized as nerve damage). Start date: 12/30/25. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/29/26 and 5/31/26. Review of Resident #312's MAR for May 2026 revealed, Order: Obtain blood glucose level one time a day for blood glucose monitoring. Start date: 4/24/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/16/26. Review of Resident #312's MAR for May 2026 revealed, Order: Assess resident for pain every shift. Start date: 11/20/25. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/29/26. Review of Resident #312's MAR for May 2026 revealed, Order: Effexor (antidepressant medication): Monitor for side effects of antidepressant use . start date: 4/20/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/29/26. Review of Resident #312's MAR for May 2026 revealed, Order: Olanzapine (antipsychotic medication). For those residents on psychoactive medications, please identify targeted behaviors to monitor .document adverse reactions in progress note and notify physician every shift. Start date: 1/20/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/29/26. Review of Resident #312's MAR for May 2026 revealed, Order: Gabapentin (medication used to treat seizures and nerve pain) 300 mg. Give 4 tablets by mouth three times a day for chronic pain. Start date: 4/7/26. Noted missing documentation to indicate if the medication was administered on the following dates: 5/29/26. Review of Resident #312's MAR for May 2026 revealed, Order: Insulin lispro (medication used to control blood sugar levels in people with diabetes) inject per sliding scale . before meals and at bedtime for type 2 diabetes. Start date: 4/30/26.Noted missing documentation to indicate if the medication was administered on the following dates: 5/29/26. Review of Resident #312's TAR for May 2026 revealed, Order: Shower/Bath Friday AM. Complete weekly skin check . skin assessment and vital signs on bath day . ensure shower form is completed. Start date: 5/15/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/15/26 and 5/23/26. Review of Resident #312's TAR for May 2026 revealed, Order: Wound Care: Left heel. Cleanse heel with generic wound cleanser two times a day for wound care. Start date: 5/19/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/20/26 and 5/22/26 and 5/27/26. Review of Resident #312's TAR for May 2026 revealed, Order: Monitor right eye cataract (clouding of the lens of the eye) every shift for right eye cataract. Start date: 5/21/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 5/15/26, 5/19/26 and 5/20/26. During an interview on 5/28/26 at 9:40 AM, Director of Nursing (DON) B confirmed that the facility was cited for noncompliance of complete and accurate medical records in April 2026, and she felt that (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility nursing staff had improved on ensuring that they were completing documentation of all medications and treatments administered, or indicating why they were missed if they were not completed. DON B reported that the facility management had been auditing resident records, and she was unaware of current concerns with nursing staff missing documentation of medications and treatments administered. Resident #313: Review of Resident 313's physician progress note dated 5/28/26, stated, (Resident #313).admitted to the skilled nursing facility for long-term care on May 26, 2026.has a chronic indwelling Foley catheter (tube inserted into the bladder to drain urine). Review of Resident #313's TAR, dated 5/1-5/31/26, included the order, Communication Order: Please open and complete sepsis (life-threatening reaction to an infection) screen in assessments every shift for sepsis screening for 7 days., start date 5/26/26, and the TAR was blank (the treatment/care was not marked as having been completed) on 5/29/26 for the section labeled, 7AM-. Review of Resident #313's TAR, dated 5/1-5/31/26, included the order, Maintain Foley Catheter and provide care every shift., start date 5/26/26, and the TAR was blank on 5/29/26 for the section labeled, 7AM-.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement its quality assurance and performance improvement policy with the potential to affect all residents of the census of 98 resulting in an adverse event not being thoroughly investigated and the potential for further repeat deficiencies and/or adverse events.Findings include:Review of the facility's Provider History Report (A Centers for Medicare and Medicaid Services' report that shows the history of deficiency citations and other related information), included repeat deficiencies for health complaint surveys, dated [DATE]-[DATE]. The citation, F0842 - Resident Records - Identifiable Information (A regulation addressing complete and accurate medical records and other medical record requirements) was cited during 4 different surveys. The two most recently cited surveys with this repeated deficiency were in the surveys dated [DATE] and [DATE]. (Note: F842 is being cited again on the survey which exited on [DATE]). The report also showed the citation, F0678 - Cardio-Pulmonary Resuscitation (CPR) (A regulation addressing cardiopulmonary resuscitation (CPR) requirements) was cited at a severity of Immediate Jeopardy (represents a situation in which noncompliance by a provider has placed the health and safety of recipients (residents) in its care at risk for serious injury, serious harm, serious impairment, or death) on a survey dated [DATE]. (Note: F678 is being cited again at the same severity and scope (how widespread the issue is) on the survey which exited on [DATE]). The report also showed, from [DATE]-[DATE], F0550 - Resident Rights/Exercise of Rights was cited 4 times and F0610 - Investigate/Prevent/Correct Alleged Violation was cited 3 times. (Note: Both F550 and F610 are being cited again on the survey which exited on [DATE]).During an interview on [DATE] at 9:40 AM, Director of Nursing (DON) B confirmed a complete and thorough investigation had not been completed when she was asked about the adverse event on [DATE] in which facility staff had a delay in starting cardiopulmonary resuscitation (CPR; an emergency lifesaving procedure performed when a person's heartbeat or breathing has stopped) and the resident (R#302) died. DON B confirmed she didn't interview any of the certified nurse aides who worked on [DATE] until [DATE]. DON B was unable to answer various investigative questions such as how often the crash cart (a specialized mobile cart used in medical facilities that contains lifesaving emergency equipment) should be checked, which staff member called 911, if an automated external defibrillator (portable electronic medical device) was used, or if any staff used oxygen on the resident. During an interview on [DATE] at 12:20 PM, Nursing Home Administrator (NHA) A reported after the adverse event on [DATE] the next QA (quality assurance)/QAPI (quality assurance and performance improvement) meeting was held on [DATE], but when asked for verification to show this adverse event was addressed at the meeting, she stated, It is not in my paperwork.I'll be honest, I can't find it in here (the QA/QAPI meeting documentation). (Note: No documentation was provided to the surveyor before the end of survey to prove the facility addressed the [DATE] adverse event in a QA/QAPI meeting following the event). NHA A reported the next QAPI meeting that would have addressed the adverse event was scheduled for [DATE], but they did not conduct the meeting because surveyors were in the building. NHA A reported the facility used two programs to track adverse events, and the adverse event on [DATE] was documented as Incident #930. NHA A confirmed the date the incident was opened (started) on [DATE]. NHA A reported the facility ended their mock (structured/simulated practice exercise often used to prepare staff to respond to a real situation) code blue (medical emergency alert often indicating someone is experiencing cardiac arrest (heart stops) and/or respiratory arrest (breathing stops) requiring an immediate response) audits that QAPI was monitoring around the end of [DATE]/Beginning of [DATE] (Note: The date of the last audit was requested from NHA A at time of interview, but was not provided before survey exit).Review of the facility's Quality Assurance and Performance Improvement (QAPI) policy, revised date [DATE], stated, .It is the policy of this facility (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program. Adverse Event is an untoward, undesirable and usually unanticipated event that causes death or serious injury, or risk thereof.The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to:.Systems and reports demonstrate systematic (refers to a step by step process that is structured, so that it can be replicated) identification.investigation, analysis, and prevention of adverse events.Program Activities.adverse events are routinely tracked.An investigation will be conducted on each identified.adverse event to analyze causes.Preventive actions and mechanisms will be implemented to prevent.adverse events, including feedback and education.Monitoring will be conducted to ensure desired outcomes are achieved and sustained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during wound care dressing changes in 3 (Residents # 306, #311, and #312) of 3 residents reviewed for wound care resulting in the potential for the introduction of infection, cross-contamination, and disease transmission.Findings include: Resident #306 Review of an admission Record revealed Resident #306 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression necrotizing fasciitis (flesh eating disease caused by bacterial infection).Review of a Minimum Data Set (MDS) assessment for Resident #306, with a reference date of 4/17/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #306 was cognitively intact.Review of Resident #306's Orders Revealed, Wound Care: irrigate RLQ (right lower quadrant) abdominal wound with saline and pat dry . Start date: 4/28/26 . In an observation and interview on 5/27/26 at 10:01 AM, Wound Care Licensed Practical Nurse (WCLPN) T entered Resident #306's room and set all of her wound care items on Resident #306's tray table that was soiled and covered with trash and old food. Noted that there was not a barrier in place on the tray table. WCLPN T then removed Resident #306's soiled dressing and packing (sterile products, typically gauze, foam, or alginate, used to fill deep or tunnel-shaped wounds to absorb exudate, control bleeding, and promote healing) from her abdomen and threw the soiled dressing, packing, and gloves that she was wearing away. WCLPN T then washed her hands with hand sanitizer and pulled a new set of gloves out of her pockets and placed the gloves on her hands. WCLPN T then cleaned out Resident #306's abdominal wound with wound cleanser and grabbed a q-tip that was sitting on Resident #306's soiled tray table without a barrier and inserted the q-tip into Resident #306's wound to measure the depth of the wound. WCLPN T removed her gloves, threw them away, and pulled another set of gloves out of her pocket and applied the new gloves without washing her hands. WCLPN T then packed Resident #306's wound with new packing that had been sitting on Resident #306's soiled tray table without a barrier and applied a new dressing to Resident #306's wound. It was noted that Resident #306's room was filthy, with pieces of trash, paper, and food remnants all over the floor, tray table, and Resident #306's bed. Resident #306's oxygen tubing was lying directly on the soiled floor, next to bedding that was soiled with brown and red stains. During an interview on 5/27/26 at 3:52 PM, Resident #306 reported that she had concerns with the way that some of the nurses were completing her wound care treatments. Resident #306 reported that she had noticed that the nurses would not typically change their gloves in between changing her soiled dressing and applying a new dressing, and that she had recently witnessed a nurse drop a wound dressing item onto the floor and then try to apply it on her wound, which she refused. Resident #311 Review of an admission Record revealed Resident #311 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcer of right heel and muscle weakness.Review of Resident #311's Orders revealed, Wound Care: Right Heel: Cleanse heel with generic wound cleanser and pat dry . Start date: 5/20/26 .During a wound care observation on 5/27/26 at 10:45 AM, WCLPN T entered Resident #311's room where he (Resident #311) was sitting in his wheelchair. WCLPN T placed all of her wound care treatment supplies on Resident #312's tray table without cleaning off the table or applying a barrier for the items. WCLPN T then applied a pair of gloves that she had pulled from her pocket and began to remove Resident #312's dressing. After removing Resident #311's soiled dressing, WCLPN T threw the dressing and her gloves away and then she pulled another set of gloves from her pocket out, applied them, and began to clean Resident #311's wound with a wound cleanser. Noted that she did not place a barrier underneath Resident #311's wound as she was cleaning it with the spray. WCLPN T' then removed her gloves, threw them away, and retrieved a set of gloves from her pocket, grabbed the dressing from the tray table and applied it to Resident #311's wound. Resident #312Review of an admission Record revealed Resident (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#312 was originally admitted to the facility on [DATE] with pertinent diagnoses which included major depressive disorder and cellulitis of the left lower limb (bacterial skin infection.)Review of Resident #312's Orders revealed, Wound Care: Cleanse right foot 3rd and 4th digits with generic wound cleanser . Start date: 5/27/26. Wound Care: Left Heel: Cleanse left heel with generic wound cleanser .Start date: 5/13/26. During a wound care observation on 5/27/26 at 10:29 AM, WCLPN T entered Resident #312's room to complete wound care on Resident #312. Noted that Resident #312 was lying on his bed. WCLPN T placed all of her wound care treatment supplies on Resident #312's tray table without cleaning off the table or applying a barrier for the items. WCLPN T began to remove Resident #312's left foot dressing by cutting the dressing wrap with scissors that were in her pocket. WCLPN T then threw away the soiled dressing and placed her scissors back in her pocket without cleaning them. WCLPN T then removed her soiled gloves and threw them away, washed her hands with hand sanitizer and pulled out a new pair of gloves from her pocket and applied them to her hands. WCLPN T then grabbed Resident #312's left foot and began to clean the wound on Resident #312's left heel with wound cleanser. It was noted that there was not a barrier underneath Resident #312's left heel, so the soiled wound cleanser was falling onto Resident #312's bed sheets. WCLPN T then placed Resident #312's left heel directly onto the bed where the soiled wound wash had spilled and began to remove the dressing on Resident #312's right foot. WCLPN T pulled her scissors out of her pocket (noted that this was the same pocket that she had her gloves in) and began to cut the soiled gauze off of Resident #312's foot. Once she removed the gauze, she placed the scissors back into her pocket without cleaning them. WCLPN T then measured Resident #312's wounds and applied new gloves from her pocket. WCLPN T then placed a wound gel on Resident #312's wound and applied new dressing.