STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235459	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Big Rapids	805 West Avenue Big Rapids, MI 49307

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness. Findings Include:On 04/20/2026 at 9:50am, observed in the residents' refrigerator located in East Hall nursing station, a 32-ounce container of Greek yogurt, that was half full, without a resident name or room number and without a date as to when the container was received or opened. When asked who was responsible for labeling the food with resident's information and the date, Dietary Manager (DM) N replied, if the food does not come from the kitchen, it is the responsibility of the staff, who placed the food in the refrigerator.According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . On 04/20/2026 at 10:12AM, observed the drain line for the ice machine does not have an air gap. The drain line opening was below the grate of the drain in the floor. According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to properly clean 1 Residents (R36's) BiPap (Bilevel Positive Airway Pressure) machine (equipment use to assist in breathing), properly clean a facility glucometer (meter used to test blood sugar) after use and fully operationalize the facility legionella prevention plan and failed to follow Enhanced Barrier Precautions during wound care.Findings included:During an observation on 4/20/26 from 4:30 PM to 4:45 PM, Licensed Practical Nurse (LPN) K was observed checking R74's, R18's, R39's and R4's blood sugar levels with a glucometer machine. LPN K was observed cleaning the glucometer monitor machine with [name brand of germicidal wipes] for 10 seconds prior to and following each blood sugar check. LPN K would wipe the machine with the germicidal wipe and then immediately dry it with a gauze pad. LPN K was also observed putting the glucometer machine in his scrub pocket after he used it on R74 and pulled it out of his pocket at the medication cart to clean it. During an observation on 4/21/26 at 8:00 AM, Licensed Practical Nurse (LPN) F was observed checking R32's blood sugar level with a glucometer machine. After checking R32's blood sugar level, LPN F cleaned the glucometer machine with an alcohol pad. LPN F stated she was taught not to use the [name brand] germicidal wipes because they can be harsh on the glucometer machines. She stated, I always use an alcohol pad. During an interview on 4/21/26 at 1:00 PM, LPN K stated he uses the purple wipes [color of the lid to the container of the [name brand] germicidal wipes) to clean glucometer machines. He stated the machine needs to be wet for 10 seconds in order for the wipe to disinfect it. During an interview on 4/22/26 at 1:50 PM, LPN H stated he cleans the glucometer machine with an alcohol swab after each use. LPN H also stated staff cannot carry the glucometer machines in their pockets. He stated they have to transport them either in a cup or on a barrier, such as a tissue. During an interview on 4/22/26 at 3:00 PM, the Director of Nursing (DON) stated staff are not supposed to carry glucometers in their pockets. She also stated the nurses are supposed to clean the glucometer machines with the [name brand] germicidal wipes and the wait time for the wipe to disinfect the machine was two (2) minutes. A review of the label on the [name brand] germicidal wipes revealed it takes 2 minutes for the wipe to disinfect an object. A review of the user's manual for the brand of glucometer that the facility uses, dated 2/16, revealed, To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions below. The meter should be cleaned and disinfected after use on each patient. The [name brand of glucometer machine] may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. Cleaning and Disinfection The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens. A variety of the most commonly used EPA (Environmental Protection Agency)-registered wipes have been tested and approved for cleaning and disinfecting of the [name brand of glucometer machine]. The disinfectant wipes listed below have been shown to be safe for use with this meter. Please read the manufacturer's instructions before using their wipes on the meter. two disposable wipes will be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	needed for each cleaning and disinfecting procedure: one wipe for cleaning and a second wipe for disinfecting. The user's manual lists the [name brand] germicidal wipes that are located in the facility's medication carts as an approved disinfection/cleaning product for their machines. The manual also lists the contact time for the [name brand] germicidal wipes that the facility uses as 2 minutes. However, the user's manual does not list alcohol pads/wipes as an approved product for disinfecting their machines. BIPAP EQUIPMENT Review of R36's admission record revealed she was admitted to the facility on [DATE] and pertinent diagnoses included: chronic respiratory failure with hypoxia, chronic diastolic (congestive) heart failure, sleep apnea, lymphedema, and peripheral vascular disease. R36 was her own responsible party. During an observation on 4/21/26 at 2:35 PM R36's BiPap machine was observed on her nightstand (not in use) R36's was sleeping. No cleaning equipment or supplies were observed in the room. Review of R36's Treatment Assessment Record (TAR) for April 2026 revealed, After resident remove CPAP/BIPAP (breathing equipment) in AM cleanse mask and reservoir with soap and water every day shift related to CHRONIC RESPIRATORY FAILURE WITH HYPOXIA; CHRONIC OBSTRUCTIVE PULMONARY DISEASE, OBSTRUCTIVE SLEEP APNEA. All the boxes were marked as completed from April 1 to April 21. Licensed Practical Nurse (LPN) K's initials were noted to be in the boxes dated 4/20/26 and 4/21/26). During an interview on 4/21/26 at 2:46 PM, (LPN) K reported he cleans the face part of R36's BiPap equipment and dumps the water reservoir and he had marked the box on R36's Treatment Assessment Record (TAR) this morning (4/21/26) indicating he had cleaned the equipment. LPN K said he was not aware there was more to cleaning the equipment. He denied cleaning the water reservoir and did not know anything about cleaning the hose to the equipment. During an interview with the Nursing Home Administrator (NHA) on 4/21/26 at 3:13 PM the NHA confirmed that they were getting more residents with C-Pap (Continuous Positive Airway Pressure) device used to treat sleep apnea, and BiPap (Bilevel Positive Airway Pressure) device used to assist breathing by delivering pressurized air through a mask) and did not currently have a respiratory therapist service available. She did not have records to indicate when R36's BIPAP machine was last checked by a Respiratory Therapist or when the mask/hoses were replaced. The NHA was not aware staff were not cleaning the water reservoir daily. There was no indication anyone had ever cleaned the hose to R36's BIPAP machine. The NHA said they did contact a respiratory care company that would start next month and they would be reviewing all residents' equipment needs and would be starting training. Review of the facility Cleaning Respiratory Equipment policy no date did not mention CPAP or BIPAP equipment. According to the American Thoracic Society, Patient Education/Information series. www.thoracic.org. What happens if I don't clean my PAP device? If you do not clean your PAP device and supplies, bacteria and mold may begin to grow. This may put you at higher risk of getting sick. Your device and supplies may be more likely to break down earlier if not kept clean. You may notice the device or mask starting to smell bad as well. Author: [NAME] Schotland. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Enhanced Barrier Precautions During a wound dressing observation for R36 on 4/21/26 at 10:30 AM, LPN K did not use a gown. There was a sign posted above R36's bed that read Enhanced Barrier Precautions. Instructions included using gloves and gowns during wound care. LPN K was asked if he needed to use a gown and he said he did not because the resident did not have an infection. There were no gowns visible in R36's room or in the hall. During an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on 4/22/26 the observations of no gown being used during wound care and no gowns being visible in the room or hall were reviewed. They confirmed that staff should be using gowns during wound care. On 04/20/2026 at 10:15AM, observed plumbing with an overhead sprayer and open spot for garbage disposal equipment, adjacent to the three-compartment sink. The drain line was capped off and water connections for garbage disposal equipment were coming out of the wall. On 04/20/2026 at 2:00PM, Maintenance Director (MD) O was asked for the facility's water management plan, at that time the CDC Toolkit: Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings, was provided. During review of the document, it was noted that the Identifying Buildings at Increased Risk page was not completed and a building water system diagram or written descriptions were not available for review. On 04/21/2026 at 7:40AM, during interview with Dietary Manager (DM) N, DM N was asked if maintenance staff came into the kitchen to flush the lines in the area where the garbage disposal used to be located, DM N asked to be shown the area they had been asked about. Upon viewing the area DM N stated that they had not seen maintenance staff flushing the lines in this area. On 04/21/2026 at 8:20AM, several documents were requested from MD O, a word description and diagram of water system for the facility, as mentioned in the water management plan document provided on 04/20/2026 and a copy of the Legionella Prevention Policy. MD O provided a copy for review, of the facility's Legionella Prevention Policy at time of request, MD O was unable to provide a copy of either a word description or diagram of the water system for the facility at time of request. On 04/21/2026 at 8:30AM, interview with MD O regarding the plumbing in the kitchen that was observed on 04/20/2026; MD O was asked if the plumbing in the area where the garbage disposal had been removed, was being flushed and if so, how often. MD O replied that the water was turned off at the site, and they were not flushing the lines. MD O then proceeded to turn on the faucet to the overhead sprayer and a small but steady flow of water came out of the sprayer. MD O further indicated the facility had hard water and that might have been a contributing factor to the valve not being fully closed and allowing water through.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation, interview, and record review, the facility failed to provide privacy for 2 of 10 residents (R3 and R39) observed during medication administration.procedures. Findings include:R3 A review of R3's admission Record, dated 4/21/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R3's admission Record revealed they had multiple diagnoses that included diabetes, dementia, post-traumatic stress disorder (PTSD), and anxiety. A review of R3's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/24/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 6 which indicated R3 was severely cognitively impaired. During an interview on 4/22/26 at 3:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) stated that it was acceptable to give a resident insulin in public areas if the resident was care planned that they did not object. Some residents don't care. The NHA and DON were asked if they considered whether other residents in the vicinity would care if they saw a resident receiving insulin and the NHA stated that as long as the resident receiving the insulin did not care it was alright to administer the insulin in a public setting. A review of R3's care plans, dated 4/1/25 to 4/22/26, failed to reveal any documentation that R3 preferred, or did not object to, receiving insulin (or any other injection) in a public area. R39 A review of R39's admission Record, dated 4/22/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R39's admission Record revealed multiple diagnoses that included diabetes and Alzheimer's Disease. A review of R39's MDS, dated [DATE], revealed they had a BIMS score of 5 which indicated they were severely cognitively impaired. During a medication administration observation on 4/20/2026 from 4:30 PM to 4:40 PM, Licensed Practical Nurse (LPN) K was observed performing blood glucose checks for R74, R18, and R39. When LPN K performed R39's blood glucose check using a lancet to draw blood, place the drop of blood on a test strip, and insert it into a portable monitoring machine, he did so in the hallway outside of the dining room while R39 was in line to get into the dining room prior to dinner. There were other residents in line and in the hallway in the vicinity of the dining room at the time of the observation that were able to observe the procedure. A review of R39's care plans, dated 4/14/25 to 4/22/26, failed to reveal any documentation that R39 preferred, or did not object to, receiving her blood glucose checks in a public area. A review of the facility's Blood Glucose Tests Nursing SOP (Standard Operating Procedures), undated, revealed, Procedure 1. Identify resident, provide privacy, and explain procedure. A review of the State Operations Manual Appendix PP, dated 7/23/25, revealed, Personal privacy includes accommodations, medical treatment, Each resident has the right to privacy and confidentiality for all aspects of care and services. A nursing home resident has the right to personal privacy of not only his or her own physical body, but of his or her personal space, including accommodations and personal care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to Intake 2724753 and Intake 2793094.Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act.and did not report an allegation of abuse and a potential crime to law enforcement for 2 of 5 residents (R77 and R85) reviewed for abuse.Findings include:According to the State Operations Manual (SOM), Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.According to the SOM, section S483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) inaccordance with State law through established procedures.R77 A review of R77's admission Record, dated 4/22/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R77's admission Record revealed multiple diagnoses that included dementia and cognitive communication deficit. A review of R77's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 4/10/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 0 which indicated R77 was severely cognitively impaired. R85 A review of R85's admission Record, dated 4/22/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R85's admission Record revealed multiple diagnoses that included bipolar disorder, dementia, and paranoid schizophrenia. A review of R85's MDS, dated [DATE], revealed they had a BIMS score of 15 which indicated R85 was cognitively intact. A review of the facility's Summary of Incident, undated, revealed on 1/19/26, R85 stated R77 entered her room without permission. R85 stated she threw a pudding cup at R77. The next day, R85 told staff that she had previously warned them that if anyone came in her room, she would hit them. She stated when R77 entered her room she pushed him back out. Staff interviews confirmed that R77 had entered R85's room but did not see any physical contact between them. When R77 had a physical assessment after the incident, he had a skin tear to his arm and bruising to his back. Appropriate treatment to R77's skin tear was performed. Staff stated they redirected R77 from R85's room and R77 was easily redirectable. The facility concluded it is probable that an unobserved physical interaction occurred between [name of R77] and [name of R85], as [name of R85] acknowledged pushing [name of R77] out of her room. A review of R77's Illustration of Documentation and Measurements of Skin Areas form, dated 1/19/26, revealed R77 had a skin tear to the outer left upper arm above the elbow and bruises to his outer left upper back between the elbow and armpit area. The skin tear and bruises in the illustration appear to be in line with each other. A review of R77's Weekly Head-To-Toe Assessment- Licensed Nurses form, dated 1/13/26 (6 days before the incident occurred), revealed, There are no skin concerns at this time and the illustrations did not show any bruises or skin tears on R77's body. A review of the [Name of County] Sheriff's Office Primary Report (police report), dated 1/26/26, revealed on 1/23/26 a deputy responded to a complaint by Adult Protective Services (APS) that stated (name redacted but identified through other documents as R85) claimed that while she was in the bathroom an unknown male entered the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathroom and she shoved him out of the bathroom. The deputy reported that he went to the facility and spoke with the Nursing Home Administrator (NHA). The NHA stated that R85 was no longer a resident at the facility and she had been transferred to another facility. The deputy asked the NHA what had occurred on 1/19/26 which was when the alleged incident had occurred. The NHA told the deputy that a male resident (R77) had walked into R85's bathroom and she had thrown a pudding cup at him. The NHA told the deputy that R77 had an open wound on his arm and they asked R85 if she had hit him or shoved him. The NHA stated that R85 initially denied that she had, but the next day she told them that she had shoved him out the door. During an interview on 4/21/2026 4:45 PM, the NHA stated they did not call the police for the incident on 1/19/26. She stated the police just showed up on 1/23/26 (4 days after the incident). The NHA stated R85 or APS must have called them. She stated they do not usually call the police, unless they can prove an actual physical altercation occurred or unless a resident has a bloody nose, a wound, or bruising. She also stated that R77 may have sustained his skin tear and bruises to his back from falling backwards. The NHA implied that R77 had a fall prior to the incident that caused R77's injuries because no one saw a physical altercation between R77 and R85. A review of R77's incident reports, dated 12/19/25 to present, failed to reveal that R77 had a fall immediately prior to the incident on 1/19/26. R77's last fall prior to 1/19/26 was on 12/21/25. R77 was not noted to have any injuries from that fall. A review of the facility's Facility Suspected Crime Report- Elder Justice Act Policy and Procedure, dated 2/17/20, revealed, The facility will comply with the Federal Elder Justice Act by ensuring that any reasonable suspicion of a crime against a resident is reported to the appropriate agency and the State Survey Agency within required timeframes. 1. The Administrator or designee, in collaboration with the Director of Nursing and appropriate facility leadership, will review the available information to determine whether there is reasonable suspicion of a crime. 2. The review may include resident statements, witness interviews, staff observations, physical assessment findings, injury type or pattern, cognitive status, behavioral history, prior allegations or patterns, and any other relevant information. 3. If reasonable suspicion of a crime is identified, the facility will report to law enforcement and/or the State Survey Agency within required timeframes. 4. If the initial information does not clearly establish reasonable suspicion of a crime, the facility will continue to investigate, monitor, reassess, and document findings. If new information later creates reasonable suspicion, reporting will be completed within the required timeframe from the point reasonable suspicion is identified. Reports will be made within the following timeframes: a. Immediately, but not later than 2 hours, if the suspected crime resulted in serious bodily injury. b. Not later than 24 hours, if the suspected crime did not result in serious bodily injury. A review of [Name of State] Criminal Law & Procedure- A Manual for [Name of State] Police Officers- Fourth Edition, dated 2019, revealed battery is A forceful, violent, or offensive touching of the person or something closely connected with the victim. A review of [Name of State] Criminal Law & Procedure- A Manual for [Name of State] Police Officers- Fourth Edition, dated 2019, revealed assault and battery is a misdemeanor offense (a crime) where 1. The defendant committed a battery on the victim. The touching must have been intended by the defendant, that is not accidental, and it must have been against the victim's will. It does not matter whether the touching caused injury. 2. The defendant intended either to commit a battery upon the victim or to make the victim reasonably fear an immediate battery.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to assess, monitor and properly treat a wound and medical condition, lymphedema for 1 resident (R36) of 3 residents reviewed for wounds and medical care.Findings included:This citation pertains to intake number 2698828Findings included:Review of R36's admission record revealed she was admitted to the facility on [DATE] and pertinent diagnoses included: chronic respiratory failure with hypoxia, chronic diastolic (congestive) heart failure, sleep apnea, lymphedema, and peripheral vascular disease. R36 was her own responsible party.During an observation and interview with R36 on 4/20/26 at 9:47 AM, R36 was in bed. Her lymphedema pump (a device that attaches to the residents' legs to provide intermittent pressure to reduce edema) was on a chair in her room with blankets over and the pump portion the leg tubing was visible. R36 said staff do not consistently put the pump on her and they do not always have time to do all her care.During an interview with Unit Manager (UM), Registered Nurse (RN) K, on 4/21/26 at 10:09 AM, UM K said she did not know anything about R36's lymphedema pump. UM K reviewed R36 Electronic Medical Record (EMR) and found a physician order for R36 to use her lymphedema pump twice a day at 45 for 45 minutes. When Reviewing R36's Treatment Administration Record (TAR) for April 2026 it was discovered there were several refusals documented and some blank areas which indicated R36 did not receive the treatment as ordered. UM K reviewed the EMR and could not locate any information on why the treatments were not given or any explanation or reason for R36's refusal to have her lymphedema treatment done. UM K said the nurse should document the reason for R36's refusals. RN Q had documented on 4/20/26 at 11:48 PM that R36 refused her lymphedema treatment. There was no documentation indicating why R36 did not want the treatment at that time.During an interview with R36 with UM K in the room on 4/21/26 at 10:27 AM, R36 denied refusing to have her lymphedema pumps on 4/20/26 at 23:48 (11:48 PM). R36 said her preferred times to use the lymphedema pumps was after lunch and between 11:00 PM and midnight daily.Review of R36's Treatment Administration Record (TAR) dated 4/1/26 to 4/30/26 revealed a treatment, leg pumps BID (twice a day) at 45 for 45 minutes every shift related to lymphedema. Each date had a day and night box. From 4/1/26 to 4/21/26 (21 boxes were coded refused and 2 boxes were blank. R36's record revealed she received the lymphedema pump treatment 18 times (treatment should have been provided 41 times). There was no explanation found in R36's EMR for the missing or refused treatments. Upon exit, the facility did not provide any additional information on R36's refusals to use her lymphedema pumps.R36 was observed during a wound treatment on 4/21/26 at 10:47 AM. R36's right lower extremity was wrapped with gauze and dated 4/20/26. Licensed Practical Nurse (LPN) K said he was the one that did the treatment on 4/20/26. When the dressing was removed approximately 1/3 of the front of R36's right leg had approximately 9 open areas (all bright red) with small amounts of healthy skin tissue between the open areas. LPN K applied a full sheet of xeroform over part of the wounds and 2 partial sheets over the rest of the wound area. The xeroform was approximately 3 inches by 4 inches. The xeroform was also applied over the healthy skin tissue. After the treatment was completed LPN K was asked if the wound was getting better. LPN K said it looked better today than it was yesterday. The surveyor explained that the last note with a description and size indicated there was only one wound and it was very small. LPN K was not aware of this and said he does not document the wound appearance when he does wound treatments or review the last note that describes the wound.Review of R36's Treatment Administration Record (TAR) dated 4/1/26 -4/30/26 revealed a treatment for, Right lower extremity: wash with wound cleanser, pat dry, apply xeroform cut to size of open areas, cover with ABD pad, wrap with roll gauze. Change daily and prn. The boxes indicating the treatment was completed were marked from 4/8/26 to 4/21/26 except for 4/16/26 which was left blank. (blank indicates the treatment was not done)Review of R36's progress noted, Late Entry dated effective 4/15/26 at 17:10 (5:10 PM) and created on 4/19/26 at 3:10 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed, Wound care provided to right lower extremity, scant serosanguinous (watery wound discharge with blood) drainage noted, total area measures 6cm x 8cm x 0.1 cm, multiple small open areas noted within the measurement, no signs or symptoms of infection noted. Wound showing signs of improvement, 100% granulation tissue, small open are decreasing in numbers.During an interview with the facility wound nurse, Licensed Practical Nurse (LPN) R and UM K on 4/21/26 at 2:21 PM, a photograph of R36's wound taken that morning was shown to LPN R in addition to a review of the last wound documentation for 4/15/26. LPN R confirmed that R36 only had one wound when she treated her on 4/15/26 and it was much smaller than the open areas today. LPN R said that it can change a lot in a week. When asked if putting xeroform over healthy skin tissue could cause it to open again LPN R responded, yes. UM K confirmed staff are not documenting the condition of the wound after each treatment and she was not able to determine when the wound declined in condition. UM K said R36's medical record did not have the wound description from 4/15/26 in it until 4/19/26 as LPN R keeps wound measurements in a book in her office and does not enter them in the medical record until she has time. UM K confirmed staff cannot assess whether a wound is improving or declining if they are not entering a description in the medical record every time a wound is observed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to properly transport a resident in a wheelchair for 1 of 21 sampled residents (R39). Findings include:A review of R39's admission Record, dated 4/22/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R39's admission Record revealed multiple diagnoses that included diabetes and Alzheimer's Disease. A review of R39's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 2/8/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 5 which indicated R39 was severely cognitively impaired. During an observation on 4/20/26 at 4:40 PM, Licensed Practical Nurse (LPN) K was observed pushing R39 in her wheelchair down the hallway from the Therapy Services Occupational Physical Speech Room to R39's room without foot pedals. LPN K just told R39 to raise her feet while she was being pushed down the hallway. During an interview on 4/22/26 at 1:50 PM, LPN H stated when staff transport a resident down the hallway, the resident is supposed to have foot pedals on their wheelchair. LPN H stated no way should a staff member transport a resident without foot pedals, even if the resident can follow instructions and raise their legs while being pushed. During an interview on 4/22/26 at 3:00 PM, the Director of Nursing (DON) stated that staff are not supposed to transport residents in wheelchairs without foot pedals. She stated she does not think the facility has a policy that covers transporting residents in wheelchairs, but it's basic nursing practice that for safety if staff push residents in wheelchairs, then they must ensure the residents have foot pedals on them.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to have ongoing respiratory assessments and documentation of use of a BiPap (Bilevel Positive Airway Pressure) machine for 1 Resident (R36) of 1 Resident reviewed for respiratory equipment use.Findings included: Review of R36's admission record revealed she was admitted to the facility on [DATE] and pertinent diagnoses included: chronic respiratory failure with hypoxia, chronic diastolic (congestive) heart failure, sleep apnea, lymphedema, and peripheral vascular disease. R36 was her own responsible party.Review of R36's physician orders dated 3/8/26 revealed, BiPap at HS (night) with the following settings: EPAP Breath rate: Min IPAP: 9Max IPAP; volume: Flex Pressure relief: on Oxygen bleed.During an interview with Unit Manager (UM) K on 4/21/26 at 2:40 PM, UM K reported that R36 frequently refuses to us her Bipap machine. The Surveyor reported that R36 had been sleeping on and off during the day and did not have the Bipap machine in use when observed today. UM K reviewed R36's Electronic Medical Record and could not locate any documents that tracked when R36 used the BiPap machine or when she was refusing it. She could not locate any BiPap assessments. There was no documentation to show when the BiPap machine was last assessed or when the BiPap therapy was reviewed for effectiveness. There was information to assist R36 with putting the BiPap on at night and for cleaning. There was no indication she should be assisted with the BiPap during the day if she was sleeping.Review of R36's Oxygen assessments revealed her Oxygen was only assessed one time in March 2026, 3/1/26 at 17:23 (5:23 PM) and was 94 with oxygen on via nasal cannula. R36's Oxygen was only assessed one time in April 2026, 4/18/26 at 17:03 (5:03 PM) and was 93 % with oxygen on via nasal cannula.Review of R36's respiratory care plan dated 2/4/26 revealed, I have altered respiratory status/difficulty breathing and potential for alteration in my respiratory status due to COPD (Chronic Obstructive Pulmonary Disease). The interventions did not include respiratory assessments, equipment assessments, amount of assistance needed or when the equipment was to be replaced or evaluated for effectiveness.During an interview with the Nursing Home Administrator (NHA) on 4/21/26 at 3:13 PM the NHA confirmed that they were getting more residents with C-Pap (Continuous Positive Airway Pressure) device used to treat sleep apnea, and BiPap (Bilevel Positive Airway Pressure) device used to assist breathing by delivering pressurized air through a mask) and did not currently have a respiratory therapist service available. The NHA said they did contact a company that would start next month and they would be reviewing all residents' equipment needs and would be starting training.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent (5%) for 2 of 7 residents (R2 and R3) observed during the medication administration task. Findings include:Resident #2 (R2) A review of R2's admission Record, dated 4/21/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R2's admission Record revealed multiple diagnoses that included diabetes. During an observation on 4/21/26 at 8:15 AM, Licensed Practical Nurse (LPN) F administered ten medications to R2, including one tablet of metformin 500 milligrams (mg) (a medication for diabetes). LPN F verbalized the medications and the doses as she was preparing them and placing them in a medication cup. A review of R2's April 2026 Medication Administration Record (MAR) revealed R2 should have received two tablets of metformin 500 mg, not one. Resident #3 (R3) A review of R3's admission Record, dated 4/21/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R3's admission Record revealed they had multiple diagnoses that included diabetes with diabetic neuropathy (nerve pain), post-traumatic stress disorder (PTSD), and anxiety. During an observation on 4/21/26 at 7:45 AM, Registered Nurse (RN) J administered nine medications to R3, including one tablet of potassium 20 mEq (milliequivalents) (a medication for potassium replacement) and one capsule of gabapentin 100 mg (a medication for neuropathy). A review of R3's April 2026 MAR revealed R3 should have received potassium 40 mEq, not potassium 20 mEq. In addition, R3's MAR revealed R3 should have received two capsules of gabapentin 100 mg, not one. During an interview on 4/21/26 at 4:51 PM, the Nursing Home Administrator and Director of Nursing were notified of the medication errors that had been observed immediately after all the medications observed during the medication observation task were reconciled with the individual residents' physician orders and MAR's.

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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, interview, and record reviw, the facility failed to secure medications in 1 of 5 medication carts (200 Hall Medication Cart) or a medication room. Findings include:During an observation on 4/20/26, Licensed Practical Nurse (LPN) K was observed walking away from the 200 Hall Medication Cart to deliver medications to another unit (LPN K had just received and signed for a pharmacy delivery for the facility). LPN K left a 30- count medication card of trazadone 50 milligrams (mg) (a medication for depression) for R15 and a 60-count medication card of acyclovir 400 mg (an antibiotic) for R76 on top of the controlled substances book on the medication cart unattended. LPN K returned to the 200 Hall Medication Cart, moved the two medication cards from on top of the controlled substances book on the right-hand side of the medication cart to the left-hand side on top of the medication cart. LPN K then continued to prepare and administer medications to residents while leaving the trazadone and acyclovir medication cards, unattended on and off, on top of the 200 Hall Medication Cart when he would leave to find the residents. This continued until 4:50 PM when LPN K saw a nurse that was assigned to another medication cart and delivered the trazadone and acyclovir to her. These two medications were then secured in another medication cart. During the entire time that the trazadone and acyclovir were left unattended and out of the sight of staff, residents were observed ambulating up and down the hallway past the medication cart and one resident was observed sitting in the vicinity of the medication cart. During an interview on 4/21/26 at 08:25 AM, LPN F stated that the nurses cannot leave medications unattended on top of the medication carts because someone might grab them and take them. During an interview on 4/21/26 at 1:00 PM, LPN K stated that you can never leave medications on the medication cart unattended because someone could come by and take them. A review of the facility's Medication Storage in the Facility policy and procedure, dated 2024, revealed that only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications (e.g., medication aides) are allowed unsupervised access to medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 of 21 sample residents (R85). Findings include: R77 A review of R77's admission Record, dated 4/22/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R77's admission Record revealed multiple diagnoses that included dementia and cognitive communication deficit. A review of R77's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 4/10/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 0 which indicated R77 was severely cognitively impaired. R85 A review of R85's admission Record, dated 4/22/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R85's admission Record revealed multiple diagnoses that included bipolar disorder, dementia, and paranoid schizophrenia. A review of R85's MDS, dated [DATE], revealed they had a BIMS score of 15 which indicated R85 was cognitively intact. A review of the facility's Summary of Incident, undated, revealed on 1/19/26, R85 stated R77 entered her room without permission. R85 stated she threw a pudding cup at R77. The next day, R85 told staff that she had previously warned them that if anyone came in her room, she would hit them. She stated when R77 entered her room she pushed him back out. Staff interviews confirmed that R77 had entered R85's room but did not see any physical contact between them. When R77 had a physical assessment after the incident, he had a skin tear to his arm and bruising to his back. Appropriate treatment to R77's skin tear was performed. Staff stated they redirected R77 from R85's room and R77 was easily redirectable. The facility concluded it is probable that an unobserved physical interaction occurred between [name of R77] and [name of R85], as [name of R85] acknowledged pushing [name of R77] out of her room. A review of R85's electronic medical record (EMR), dated 12/19/25 to 4/21/26, failed to reveal any information that R85 was involved in any incident on 1/19/26. During an interview on 4/21/26 at 4:45 PM, the Nursing Home Administrator (NHA) confirmed that there was not any documentation in R85's medical record that stated an incident had occurred on 1/19/26. She stated her Social Services Director was off at the time and they had someone filling in. The NHA stated that even though the other social worker did wellness visits, the documentation did not specify if the visits were from an incident or were just visits by the social worker to check on R85's general welfare. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care- Assessments; Clinical problems; Communications with other health care professionals regarding the patient; Communication with and education of the patient, family, and the patient's designated support person and other third parties. Patient responses and outcomes, including changes in the patient's status. Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 7/27/25).