STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Galesburg	1080 N 35th Street Galesburg, MI 49053

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #2792486Based on interview and record review, the facility failed to ensure facility staff implement the facility abuse policy and procedure for 3 residents (Resident #112, Resident #104, and Resident #102) of 9 residents reviewed for abuse, resulting in incidents of potential abuse not being reported to the abuse coordinator immediately. Findings include:Resident #112Review of an admission Record revealed Resident #112 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: insomnia (a sleep disorder characterized by persistent difficulty falling asleep) and vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain, robbing brain cells of oxygen).Review of a Minimum Data Set (MDS) assessment for Resident#112 with a reference date of 1/30/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12/15, which indicated the resident was moderately cognitively impaired.Review of Physician Orders for Resident #112 with a reference date of 1/30/26 revealed a one-time order, diphenhydramine HCl (hydrochloride) 25mg(milligrams), give 2 tablets by mouth one time only. No other orders for the use of diphenhydramine were present for Resident #112.In an interview on 3/31/26 at 11:34am, Resident #112 reported a male nurse had been giving him (brand name of diphenhydramine omitted) for at least a few weeks because it helped him sleep. Resident #112 reported he was recently told by a female nurse that the use of diphenhydramine was not recommended for those with dementia because it worsen his cognitive skills. Resident #112 reported he had trouble sleeping for many years and prior to his admission, he used the medication nightly. When further queried about his concern with taking diphenhydramine at this time, Resident #112 stated I don't need anything to make my memory worse, so I don't want any more of that!In an interview on 3/27/26 at 11:45am, LPN K reported she was concerned LPN M was giving residents in memory care medications that he shouldn't. When asked to explain, LPN K reported she was concerned LPN M gave residents diphenhydramine, an over-the-counter allergy medication known to cause drowsiness, without a physician's order. LPN K reported a male resident asked her several times for the medication and when she told him he didn't have an order for it, the resident said, the other nurse gives it to me. LPN K reported then she found an opened bottle of diphenhydramine HCl in the medication room on the memory care unit. LPN K reported it appeared quite a bit of the medication was gone but none of the resident's on the unit had an order for diphenhydramine HCl. LPN K reported LPN M recently stated to her We'll be ok tonight. I made sure everyone is going to sleep tonight. LPN K reported after her conversation with LPN M, she removed the open bottle of diphenhydramine from the medication storage room, but a new bottle was in its place the following night. LPN K reported she then told the supply clerk to take the medication out of the storage room and stop stocking it because she was concerned another nurse was giving it to residents without an order to do so. When queried, LPN K reported she did not report the concern to (NHA) A because she did not have proof of her allegation that residents were being administered medication without a physician's order.In an interview on 3/27/26 at 2:43pm, Supply Clerk (SC) AA reported she stocked all the over-the-counter medications in each medication storage room throughout the facility. SC AA reported she did not keep a running total of the over-the counter (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications she stocked, or the amount stored in the main stock room. SC AA reported all nurses have a key to the main stock room. SC AA reported she recently noticed a bottle of diphenhydramine was missing from the medication storage room on the memory care unit, so she restocked it with a new bottle. SC AA reported on 3/26/26, LPN K told her to stop stocking diphenhydramine in the memory care medication storage room because she was concerned another nurse was giving to residents without a physician's order. When queried, SC AA reported she did not tell NHA A about the allegation of resident's receiving medication without a physician's order.Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: generalized anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, lasting at least 6 months).Review of a Minimum Data Set (MDS) assessment for Resident #104 with a reference date of 1/28/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section D revealed Resident #104 reported he felt down, depressed, or hopeless several days during the 14-day assessment period. Section E revealed Resident #104 had no behaviors.Review of a Care Plan for Resident #104 with reference date of 11/19/25 revealed the following need/goal/interventions: (Resident #104) is at risk for adverse reactions and side effects r/t (related to) receiving an antidepressant. Goal: Will show decreased episodes of s/sx (signs and symptoms) of anxiety through the review date. Interventions. observe ongoing s/sx of depression.In an interview on 3/26/26 at 11:17am Resident #104 reported he told a staff member he thought two of his video games, valued at $160 dollars, had been stolen. Resident #104 reported he did not know the name or position of the staff member. Resident #104 reported the staff member told him the games were not on his inventory list and would not be replaced. Resident #104 reported he never told NHA A because he thought nothing could be done.In an interview on 3/31/26 at 4:22pm, NHA A reported staff never told him Resident #104 made an allegation of misappropriation of his video games. NHA A confirmed this allegation was never reported to the state agency and was never investigated.Resident #102Review of an admission Record revealed Resident #102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (condition causing progressive loss of cognitive skills), bipolar disorder (chronic mental health condition causing extreme, disabling shifts in mood) and general anxiety disorder (mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday things).Review of a Minimum Data Set (MDS) assessment for Resident #102 with a reference date of 3/4/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3/15, which indicated the resident was severely cognitively impaired. Section A of the MDS revealed Resident #102 had unclear speech and her ability to make herself understood was limited to concrete requests.Review of a Care Plan for Resident #102 with a reference date of 3/16/23 revealed the following need/goal/interventions: Need: (Resident #102) is at risk for impaired skin integrity.Goal: Minimize risk in effort to reduce likelihood of pressure injury.Interventions:.conduct weekly head to toe skin assessments, document and report abnormal findings to physician.follow facility policies.In an interview on 3/26/26 at 2:03pm, former Director of Nursing (DON) WW reported Resident #102 had a bruise of unknown origin on her forearm that was not immediately reported by floor staff. DON WW reported she realized the resident had an injury when she saw it documented on CNA alert charting a day after it was first identified.Review on an Incident Report for Resident #102 with a reference date of 1/19/26 revealed staff reported that the bruise was first noted on night shift by the assigned nurse on 1/18/26.In an interview on 3/26/26 at 12:44pm, CNA QQ reported on the morning of 1/19/26, at approximately 6:30am, she was told by a member of the off-going shift that Resident #102 had a bruise of unknown origin on her forearm. CNA QQ reported she knew the bruise should have been reported when it was identified so she alerted the Former DON WW. CNA QQ reported the bruise extended from the resident's wrist to the top of the forearm and covered most of the dorsal (top) surface of her forearm.Review of a Provider Progress Note for Resident #102 with a reference date of (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/19/26 at 8:00am revealed .New right forearm bruise.acute visit for new right forearm bruise.contusion(bruise) of right upper arm.right dorsal forearm bruise, unknown mechanism of injury.Review of a Nursing Progress Note for Resident #102 with a reference date of 1/19/26 at 9:08am revealed .skin issues note: bruised right forearm.Review of an Facility Reported Incident report for Resident #102, with a reference date of 1/19/26, revealed the information was submitted to the state agency at 1:48pm for the injury of unknown origin that was identified on 1/18/26. Of note, the report was not submitted with the required 2-hour time frame.In an interview on 3/31/26 at 4:22pm, NHA A reported it was the expectation that staff would report a concern of resident abuse to him immediately.Review of a facility Abuse Prohibition Policy with a reference date of 9/9/22 revealed .It is the responsibility of all staff to provide a safe environment for the residents. Definitions.f resident abuse.adverse event.mistreatment shall be thoroughly investigated and documented by the Administrator and reported to the appropriate state agencies. Staff members.shall immediately report incidents of abuse and suspected abuse, . Definitions:.Neglect is the failure of employees to provide.services to a resident.to avoid physical harm, mental anguish or emotional distress.Misappropriation: means.deliberate misplacement.of a resident's belongings.Adverse event is an.undesirable.event that causes.serious injury.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2792486,2735355 and #2793260.Based on interview, and record review, the facility failed to report allegations involving potential abuse, neglect, or mistreatment to the State Agency timely and accurately in 3 (Resident #107, #112, and #100) of 6 residents reviewed for reporting, including an alleged incident of mistreatment when Resident #107 was hit with a medication cart causing a fall with major injury, allegations of abuse (Resident #100 and Resident #112), resulting in the potential delay in actions to maintain the safety of facility residents and for allegations of abuse to not be reported timely and accurately. Findings include:Resident #107 Review of an admission Record revealed Resident #107 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (progressive disease that causes loss of cognitive abilities), moderate, with anxiety (persistent feelings of apprehension, dread and nervousness). Review of a Minimum Data Set (MDS) assessment for Resident #107 with a reference date of 11/17/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 11/15, which indicated the resident was moderately cognitively impaired. Section GG of the MDS revealed Resident #107 was independent (completed activity by themselves with a device) for walking. Section J revealed Resident #107 had a fall in the month prior to her admission to the facility. Review of a Care Plan for Resident #107 with a reference date of 11/11/25 revealed the following need/goal/interventions: (Resident #107) is at risk for fall related injury and falls R/T (related to) poor safety awareness. Goal: will be free from injury related to falls through the review date. Interventions: Educate.caregivers about safety reminders.keep resident's environment as safe as possible.remind resident to take her time when walking. Review of a Fall Report for Resident #107, dated 1/24/26 at 7:00pm, revealed Incident Description.Nurse was pushing medication cart and collided with resident. Fall was witnessed.complained of R (right) hip pain.Xray was ordered.results of Xray showed acute R femoral neck fracture (break in the narrow, upper part of the thigh bone, just below the ball of the hip joint, often caused by falls). Resident left via EMS (emergency medical services) . Review of a Post Fall Evaluation for Resident #107, with a reference date of 1/24/26, revealed Staff/witness present at/or observing resident after fall: (Name omitted (Certified Nursing Assistant (CNA) II, CNA MM.Factors observed at time of fall.Environmental factors: Cart pushed in hall tripped resident.Re-Creation of Last 3 Hours Before Fall: the primary nursing assistant who observed the resident during the three hours prior to the fall was interviewed: (Name Omitted) Laundry Aide (LA) BB.Root Cause of this Fall: .Environmental factors.Nurse Signature: (Name Omitted) Licensed Practical Nurse (LPN) K. In an interview on 3/25/26 at 10:25am, CNA II reported she was at the nurse's station on 1/24/26 when she heard Resident #107 and LPN K begin to scream. She responded and saw Resident #107 on the floor on her back and LPN K reported she accidentally hit the resident with the medication cart. When queried regarding other staff that were present, CNA II reported former CNA VV was present when the accident occurred and (LA) BB was down the hall. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/31/26 at 7:54am, CNA MM reported she was not present on 1/24/26 when Resident #107 fell. CNA MM reported she saw Resident #107 later that evening before she was sent to the hospital. Of note, this contradicts the information LPN K documented in the Post Fall Evaluation. In an interview on 3/27/26 at 11:04am, former CNA VV reported she witnessed Resident #107's fall on 1/24/26 because the resident was next to her when she was hit by the cart. CNA VV reported she was pushing another resident in a wheelchair as Resident #107 walked next to her using her walker. CNA VV reported she and Resident #107 walked on the left side of the hall with Resident #107 on CNA VV's right side, near the middle of the hall. CNA VV heard LPN K sigh loudly as she approached them from behind while pushing the medication cart. CNA VV reported it sounded like the medication cart was rapidly approaching them from behind and as she turned toward LPN K, she saw the LPN K quickly approaching with the medication cart, and one side of the medication cart began to swing toward Resident #107. CNA VV reported it looked like LPN K did not have control of the cart as one end of it swung toward them and hit the back of Resident #107's leg, causing the resident to fall to the floor. CNA VV reported she was concerned that LPN K was upset about an interaction the two of them had earlier in the day and was pushing the medication cart recklessly in frustration. When queried if she reported her concern to Nursing Home Administrator (NHA) A, CNA VV confirmed she texted and called NHA A. CNA VV reported she left a voice mail message for NHA A who then called her back with a three-way call, that included former DON WW, about an hour later. CNA VV reported at that time she told both NHA A and DON WW she felt Resident #107 had been injured as a result of the reckless actions of LPN K. CNA VV reported NHA A did not ask her for any additional information and disregarded her concerns. CNA VV reported she was never interviewed about the situation. Of note, CNA VV is not listed as a witness in the Post Fall Evaluation completed by LPN K. In an interview on 3/27/26 ay 11:45am, LPN K reported she was pushing the medication cart down the hall behind Resident #107 on 1/24/26. When asked to describe what happened during the accident, LPN K stated She zigged when I zagged and she backed into the cart. LPN K confirmed that both she and Resident #107 were in motion when Resident #107 was knocked off balance by the medication cart. LPN K reported Resident #107 fell on the floor and was so dramatic as she lay on the floor yelling ohhhh. LPN K confirmed Resident #107 suffered a broken hip during the fall. LPN K confirmed she was not interviewed for additional information after she called NHA A on 1/24/26. In an interview on 3/31/26 at 2:00pm, NHA A reported on 1/24/26 LPN K called him to report that Resident #107 fell. NHA A reported it was his understanding that Resident #107 was startled by LPN K, lost her balance, and fell but was not hit by the medication cart. NHA A reported he didn't have any red flags about the situation during which Resident #107 had a fall with major injury because LPN K called him. When further queried, NHA A reported he did not think the nurse would have called him right away if she'd done something wrong, so he did not report or investigate the situation any further. When asked if he spoke with CNA VV about her concerns, NHA A reported he could not recall what the CNA told him, but the CNA had mentioned a concern that the nurse may not have accurately reported what had happened. Review of a QAPI (Quality Assurance Performance Improvement Review signed by NHA A revealed On 1/24/26 (Resident #107) the Administrator received a phone call from (LPN K).LPN K stated she had been pushing the cart down the hall and (Resident #107) was walking near her.(LPN K) tried to be (sic) out of her way-she (Resident #107) stopped walking and backed up a step and clipped the corner of the cart; she (Resident #107).fell on her buttocks.LPN K.didn't know (Resident #107) was so close (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to her.(LPN K) was verbally educated to pull her cart rather than pushing her cart to ensure no residents step in front of her while in mostion (sic) Review of the Facility Reported Incident database revealed the facility did not report any allegations of potential mistreatment for Resident #107. Resident #112 Review of an admission Record revealed Resident #112 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: insomnia (a sleep disorder characterized by persistent difficulty falling asleep) and vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain, robbing brain cells of oxygen). Review of a Minimum Data Set (MDS) assessment for Resident#112 with a reference date of 1/30/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12/15, which indicated the resident was moderately cognitively impaired. Review of Physician Orders for Resident #112 with a reference date of 1/30/26 revealed a one-time order, diphenhydramine (antihistamine that is used to help treat certain allergy or common cold symptoms, allergic reactions, trouble sleeping, motion sickness, or certain movement problems) HCl (hydrochloride) 25mg(milligrams), give 2 tablets by mouth one time only. No other orders for the use of diphenhydramine were present for Resident #112. In an interview on 3/31/26 at 11:34am, Resident #112 reported a male nurse had been giving him (brand name of diphenhydramine omitted) for at least a few weeks because it helped him sleep. Resident #112 reported he was recently told by a female nurse that the use of diphenhydramine was not recommended for those with dementia because it could worsen his cognitive skills. Resident #112 reported he had trouble sleeping for many years and prior to his admission, he used the medication nightly. When further queried about his concern with taking diphenhydramine at this time, Resident #112 stated I don't need anything to make my memory worse so I don't want anymore of that! In an interview on 3/27/26 at 11:45am, LPN K reported she was concerned LPN M was giving residents in memory care medications that he shouldn't. When asked to explain, LPN K reported she was concerned LPN M gave residents diphenhydramine, an over-the-counter allergy medication known to cause drowsiness, without a physician's order. LPN K reported a male resident (Resident #112) asked her several times for the medication and when she told him he didn't have an order for it, the resident said, the other nurse gives it to me. LPN K reported then she found an opened bottle of diphenhydramine HCl in the medication room on the memory care unit. LPN K reported it appeared that quite a bit of the medication was gone but none of the residents on the unit had an order for diphenhydramine HCl. LPN K reported LPN M recently stated to her We'll be ok tonight. I made sure everyone is going to sleep tonight. LPN K reported after her conversation with LPN M, she removed the open bottle of diphenhydramine from the medication storage room, but a new bottle was in its place the following night. LPN K reported she then told the supply clerk to take the medication out of the storage room and stop stocking it because she was concerned another nurse was giving it to residents without an order to do so. When queried, LPN K reported she did not report the concern to NHA A because she did not have proof of her allegation that residents were being wrongfully medicated. Attempts to interview LPN K for additional information were unsuccessful by the completion of the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	survey. Attempts to interview LPN M were unsuccessful by the completion of the survey. In an interview on 3/27/26 NHA A reported the facility was aware of an allegation of misuse of diphenhydramine and an investigation was underway. In an interview on 3/31/26 NHA A reported he spoke with LPN K and she expressed general concerns about finding diphenhydramine in the medication storage room on the memory care unit. When queried, NHA A denied that LPN K reported an allegation that LPN M was using the medication to make residents sleep at night. NHA A confirmed this allegation would be investigated and reported. In an interview on 3/31/26 at 2:21pm, Nurse Practitioner (NP) XX reported none of the residents on the memory care unit had an order to receive diphenhydramine. NP XX reported the use of that medication for those with dementia created a higher risk for falls and had a sedating effect on the patients. Review of the state agency Facility Reported Incidents data base of 4/1/26 at 3:45pm, revealed the facility had not submitted the allegation of potential mistreatment or abuse for Resident #112. Review of a facility Abuse Prohibition Policy with a reference date of 9/9/22 revealed .It is the responsibility of all staff to provide a safe environment for the residents. Allegations of resident abuse.adverse event.mistreatment shall be thoroughly investigated and documented by the Administrator and reported to the appropriate state agencies. Definitions:.Neglect is the failure of employees to provide.services to a resident.to avoid physical harm, mental anguish or emotional distress.Misappropriation: means.deliberate misplacement.of a resident's belongings.Mistreatment means inappropriate treatment or exploitation of a guest/resident .Adverse event is an.undesirable.event that causes.serious injury.Reporting abuse and facility Response to the allegation.2. The Administrator or designee will notify.any State or Federal agencies of allegations per state guidelines (2 hours if abuse allegation or serious injury) . Resident #100 Review of an admission Record revealed Resident #100 was a female, with pertinent diagnoses which included heart failure, insomnia, post-traumatic stress disorder, bipolar disorder, dementia, anxiety, obstructive lung disease, arthritis, a history of falls, and hearing loss. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 2/9/26, revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, indicating she had severe cognitive impairment. In an interview on 3/26/26 at 9:27 AM, Licensed Practical Nurse (LPN) R reported she was Resident #100's assigned nurse on 1/22/26 for day shift. LPN R reported she went into Resident #100's room on 1/22/26 in the morning to complete her rounds, and as LPN M walked by the door Resident #100 told LPN R to not let him (LPN M) in the room because LPN M had grabbed her arm. LPN R reported she observed a bruise on Resident #100's left arm and notified Administrator A immediately of Resident #100's allegation of potential abuse. LPN R stated .She (Resident #100) was frightened .She is usually not afraid . LPN R reported Resident #100 made the allegation .early in the morning . around 6:30 AM-7:00 AM, and the administration was notified .right away . via phone. LPN R reported (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator A directed her to monitor the bruise on Resident #100's arm, and he would report the allegation and handle the investigation. LPN R reported Resident #100 has a history of refusing care, and if staff keep trying, she will often become more combative. LPN R reported when Resident #100 becomes combative, staff are to step away and give her space to calm down before re-approaching. LPN R stated .sometimes all it takes is a different person to approach her . and she will accept care. LPN R reported Resident #100 is not good at communicating her needs vocally and has impaired hearing. LPN R reported she did not document her observation of the bruise on Resident #100's arm because .I didn't know what (Administrator A) wanted me to do . Review of an incident/accident report for Resident #100, dated 1/22/26 at 8:00 AM, revealed .Resident reported to nurse (LPN R) that during last rounds night shift nurse and (CNA) came into the room and changed her even though she verbalized that she was not wet and nurse (LPN M) held her wrists while CNA provided (incontinence) care .Resident Description: He grabbed my arms and twisted them, it hurt and I told him I was not very wet .Nurse assessed resident and observed a bruise on left arm. Nurse noted redness on the left arm, no other bruising noted .nursing immediately reported to (Administrator A), report filed with Michigan . Review of a Resident at Risk note for Resident #100, dated 1/22/26 at 9:30 AM, revealed .IDT (Interdisciplinary Team) met to discuss plan of care for resident who is long-term resident in the facility on hospice services, no plan to dc (discharge) home .Action Taken: Nursing assessed resident, bruise on left arm noted redness on right arm, pain managed with scheduled pain medications .Order for X-ray .Nursing to continue to monitor psychosocial status . Review of the MI-FRI System (a system for long-term care facilities to report Facility Reported Incidents) revealed the incident involving Resident #100 on 1/22/26 was reported to the State Agency via online submission on 1/22/26 at 11:40 AM (more than two hours after the allegation of abuse was made). Noted the documentation within the MI-FRI system indicated the incident was discovered (identified) at 10:00 AM despite being informed by LPN R of the concern between 6:30-7:00am that morning. In an interview on 3/31/26 at 3:37 PM, Administrator A reported he was notified of Resident #100's allegation involving a potential staff-resident abuse situation on 1/22/26 in the morning (on day shift). Administrator A reported Former Director of Nursing (DON) WW learned of the allegation from LPN R and came directly to his office to discuss the concern. Administrator A reported he did not recall receiving a phone call from LPN R prior to that point involving the allegation made by Resident #100. Administrator A reported Resident #100 told LPN R that LPN M had twisted her arm, and a bruise was noted on Resident #100's left arm. Administrator A indicated he reported the allegation of abuse involving Resident #100 to the State Agency, however, there was an issue with the MI-FRI system that day and he had to notify IT for additional assistance. Administrator A reported he was unsure when he first attempted to report the allegation of abuse to the State Agency on 1/22/26 and stated .I don't have a record of that . Administrator A reported that an allegation of abuse should be reported to the State Agency within two hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2735355Based on interview and record review, the facility failed to identify and thoroughly investigate situations involving potential abuse for 2 residents (Resident #107 and Resident #112) of 9 residents reviewed for abuse, resulting in the potential for ongoing abuse due to an incomplete investigation.Findings include:Resident #107Review of an admission Record revealed Resident #107 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (progressive disease that causes loss of cognitive abilities), moderate, with anxiety (persistent feelings of apprehension, dread and nervousness).Review of a Minimum Data Set (MDS) assessment for Resident #107 with a reference date of 11/17/25, revealed Section GG of the MDS revealed Resident #107 was independent (completed activity by themselves with a device) for walking.Review of a Care Plan for Resident #107 with a reference date of 11/11/25 revealed the following need/goal/interventions: (Resident #107) is at risk for fall related injury and falls R/T (related to) poor safety awareness. Goal: will be free from injury related to falls through the review date. Interventions: Educate.caregivers about safety reminders.keep resident's environment as safe as possible.remind resident to take her time when walking.Review of a Fall Report for Resident #107, dated 1/24/26 at 7:00pm, revealed Incident Description.Nurse was pushing medication cart and collided with resident. Fall was witnessed.complained of R (right) hip pain.Xray was ordered.results of Xray showed acute R femoral neck fracture (break in the narrow, upper part of the thigh bone, just below the ball of the hip joint, often caused by falls). Resident left via EMS (emergency medical services) .Review of a Post Fall Evaluation for Resident #107, with a reference date of 1/24/26, revealed Staff/witness present at/or observing resident after fall: (Name omitted, Certified Nursing Assistant (CNA) II, CNA MM).Factors observed at time of fall.Environmental factors: Cart pushed in hall tripped resident.Re-Creation of Last 3 Hours Before Fall: the primary nursing assistant who observed the resident during the three hours prior to the fall was interviewed(print the name of the assistant): (Name Omitted, Laundry Aide (LA) BB).Root Cause of this Fall: .Environmental factors.Nurse Signature: (Name Omitted) Licensed Practical Nurse (LPN) K.In an interview on 3/31/26 at 7:54am, CNA MM reported she was not present on 1/24/26 when Resident #107 fell. CNA MM reported she saw Resident #107 later that evening before she was sent to the hospital. Of note, this contradicts the information LPN K documented in the Post Fall Evaluation.In an interview on 3/27/26 at 3:50, Laundry Aide (LA) BB reported she was on the memory care unit, in the hallway on 1/24/26 when Resident #107 fell and was injured. LA BB reported she was standing in the hallway, between rooms [ROOM NUMBERS] facing the west wall, looking at the name tag in a piece of personal laundry when out of her peripheral vision, she saw Resident #107 walking next to CNA VV as they walked toward here from the south. LA BB reported the resident fell and she saw LPN K, the medication cart, and CNA VV all right there together. LA BB reported she did not know if the cart hit the resident or not. LA BB reported she was never interviewed by Nursing Home Administrator (NHA) A regarding what she saw during the incident involving Resident #107 on 3/27/26.In an interview on 3/27/26 at 11:04am, former CNA VV reported she witnessed Resident #107's fall on 1/24/26 because the resident was next to her when she was hit by the cart. CNA VV reported she was pushing another resident in a wheelchair as Resident #107 walked next to her using her walker. CNA VV reported she and Resident #107 walked on the left side of the hall with Resident #107 on CNA VV's right side, near the middle of the hall. CNA VV heard LPN K sigh as she approached them from behind while pushing the medication cart. CNA VV reported it sounded like the medication cart was rapidly approaching them from behind and as she turned toward LPN K, she saw the LPN K quickly approaching with the medication cart, and one side began to swing toward Resident #107. CNA VV reported it looked like LPN K did not have control of the cart as one end of it swung toward them and hit the back of Resident #107's leg, causing the resident to fall to the floor. CNA VV reported she was concerned that (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN K was upset about an interaction the two of them had earlier in the day and was pushing the medication cart recklessly in frustration. When queried if she reported her concern to NHA A, CNA VV reported she told both NHA A and Director of Nursing (DON) WW in an 3-way telephone call on 1/24/26 that she felt Resident #107 had been injured as a result of the reckless actions of LPN K. CNA VV reported NHA A did not ask her for any additional information and disregarded her concerns. CNA VV reported she was never interviewed about the situation. Of note, CNA VV is not listed as a witness in the Post Fall Evaluation completed by LPN K.In an interview on 3/27/26 ay 11:45am, LPN K reported she was pushing the medication cart down the hall behind Resident #107 on 1/24/26 at approximately 6:45pm. When asked to describe what happened during the accident, LPN K stated She zigged when I zagged and she backed into the cart. LPN K confirmed that both she and Resident #107 were in motion when Resident #107 was knocked off balance by the medication cart. LPN K reported Resident #107 fell on the floor and was so dramatic as she lay on the floor yelling ohhhh. LPN K confirmed Resident #107 suffered a broken hip during the fall. LPN K confirmed she was not interviewed for additional information after she called NHA A on 1/24/26.Review of a soft file provided by NHA A revealed a summary which stated On 1/24/26, the Administrator received a phone call from (LPN K) regarding a witnessed fall.LPN K stated that she had been pushing the cart down the hallway and (Resident #107) was walking near her.LPN K saw her (Resident #107) and tried to be (sic) out of her way -she (Resident #107) stopped walking and backed up a step and clipped the corner of the cart; she lost her balance and fell to her buttocks.LPN K stated that it was an accident, and she didn't know (Resident #107) was so close to her. The document was signed by NHA A.In an interview on 3/31/26 at 2:00pm, NHA A reported on 1/24/26 LPN K called him to report that Resident #107 fell. NHA A reported it was his understanding that Resident #107 was startled by LPN K, lost her balance, and fell but he did not know if the resident was hit by the cart. NHA A reported he didn't have any red flags about the situation during which Resident #107 had a fall with major injury because LPN K called him. NHA A described the investigation of the incident as brief. When further queried, NHA A stated When an LPN calls and tells you exactly what happened, there was little need for an investigation. When asked if he spoke with CNA VV about her concerns, NHA A reported he could not recall what the CNA told him, but the CNA had mentioned a concern that the nurse may not have accurately reported what had happened. NHA A could not confirm speaking to any other witnesses, including LA BB. NHA A did not elaborate or look into whether any other interaction had occurred earlier in the day as reported by CNA VV that may have contributed to the incident.Resident #112Review of an admission Record revealed Resident #112 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: insomnia (a sleep disorder characterized by persistent difficulty falling asleep) and vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain, robbing brain cells of oxygen).Review of a Minimum Data Set (MDS) assessment for Resident#112 with a reference date of 1/30/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12/15, which indicated the resident was moderately cognitively impaired.Review of Physician Orders for Resident #112 with a reference date of 1/30/26 revealed a one-time order, diphenhydramine (an over-the-counter allergy medication known to cause drowsiness) HCl (hydrochloride) 25mg(milligrams), give 2 tablets by mouth one time only. No other orders for the use of diphenhydramine were present for Resident #112.In an interview on 3/31/26 at 11:34am, Resident #112 reported a male nurse had been giving him (brand name of diphenhydramine omitted) for at least a few weeks because it helped him sleep. Resident #112 reported he was recently told by a female nurse that the use of diphenhydramine was not recommended for those with dementia because it can worsen his cognitive skills. Resident #112 reported he had trouble sleeping for many years and prior to his admission, he used the medication nightly. When further queried about his concern with taking diphenhydramine at this time, Resident #112 stated I don't need anything to make my memory worse, so I don't want any more of that!In an interview on 3/27/26 at 11:45am, LPN K reported she was concerned LPN M was giving residents in (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	memory care medications that he shouldn't. When asked to explain, LPN K reported she was concerned LPN M gave residents diphenhydramine, an over-the-counter allergy medication known to cause drowsiness, without a physician's order. LPN K reported a male resident (Resident #112) asked her several times for the medication and when she told him he didn't have an order for it, the resident said, the other nurse gives it to me. LPN K reported then she found an opened bottle of diphenhydramine HCI in the medication room on the memory care unit. LPN K reported it appeared that quite a bit of the medication was gone but none of the residents on the unit had an order for diphenhydramine HCI. LPN K reported LPN M recently stated to her We'll be ok tonight. I made sure everyone is going to sleep tonight. LPN K reported after her conversation with LPN M, she removed the open bottle of diphenhydramine from the medication storage room, but a new bottle was in its place the following night. LPN K reported she then told the supply clerk to take the medication out of the storage room and stop stocking it because she was concerned another nurse was giving it to residents without an order to do so. When queried, LPN K reported she did not report the concern to NHA A because she did not have proof of her allegation that residents were being wrongfully medicated. In an interview on 3/31/26 at 2:21pm, Nurse Practitioner (NP) XX reported none of the residents on the memory care unit had an order to receive diphenhydramine. NP XX reported the use of that medication for those with dementia created a higher risk for falls and had a sedating effect on the patient.In an interview on 3/27/26 NHA A reported the facility was aware of an allegation of misuse of diphenhydramine and an investigation was underway.Review of a soft file provided by NHA A related to improper administration of diphenhydramine to residents, revealed the facility interviewed 9 of 27 licensed nurses employed by the facility. No record of LPN K being interviewed was provided.In an interview on 3/31/26 NHA A reported he spoke with LPN K, and she expressed general concerns about finding diphenhydramine in the medication storage room on the memory care unit. When queried, NHA A denied that LPN K reported an allegation that LPN M was giving the medication to residents without a physician's order to make them sleep at night. NHA A confirmed this allegation would be investigated and reported.Review of the state agency Facility Reported Incidents data base of 4/1/26 at 3:45pm, revealed the facility had not submitted an investigation related to the accusation of a nurse giving residents diphenhydramine without an order.Review of a facility Abuse Prohibition Policy with a reference date of 9/9/22 revealed .It is the responsibility of all staff to provide a safe environment for the residents. Allegations of resident abuse.adverse event.mistreatment shall be thoroughly investigated and documented by the Administrator and reported to the appropriate state agencies.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to provide timely incontinence care in 1 of 4 residents (Resident #100) reviewed for dignity and timely response to resident needs, resulting in frustration and the potential for impaired dignity, infection, falls, and skin breakdown.Findings include:Resident #100Review of an admission Record revealed Resident #100 was a female, with pertinent diagnoses which included heart failure, insomnia, post-traumatic stress disorder, bipolar disorder, dementia, anxiety, obstructive lung disease, arthritis, a history of falls, and hearing loss.Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 2/9/26, revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, indicating she had severe cognitive impairment. Noted Resident #100 was frequently incontinent of urine and always incontinent of bowel.Review of a current Care Plan for Resident #100 revealed the need .risk for fall related injury and falls . revised 1/15/26, with interventions which included .Remind her frequently to use call light when assistance is needed . initiated 9/14/23.Review of a current Care Plan for Resident #100 revealed the need .at risk for impaired skin integrity/pressure injury . revised 10/6/23, with interventions which included .Complete hygiene care expeditiously and calmly to minimize duration of distress when the resident is uncooperative . initiated 1/29/26.In an observation on 3/31/26 at 11:02 AM, Resident #100 was noted in bed in her room. Observed that her call light was activated, with a light illuminated above her door frame. Observed Activity Assistant X respond to Resident #100's activated call light, and approach Resident #100 to identify what she needed. Observed Resident #100 request a brief change. Noted Activity Assistant X deactivated Resident #100's call light (with the need unmet) and informed Resident #100 she would need to get additional staff to help with the care. Activity Assistant X then exited Resident #100's room and continued down the hall. Observed Resident #100 appeared calm, with no negative mood or behaviors identified during this interaction.In an observation on 3/31/26 at 11:32 AM, Resident #100 was noted in bed in her room, lying on her right side with her hands folded under her head and her eyes closed. Noted that staff had not yet returned to Resident #100's room to assist with a brief change (per her request) since her call light was answered and deactivated at 11:02 AM (30 minutes prior).In an interview on 3/31/26 at 11:35 AM, Activity Assistant X reported when she responded to Resident #100's call light at 11:02 AM, the resident requested a brief change. Activity Assistant X reported she told the resident she would let someone (from nursing) know. Activity Assistant X reported she was not yet able to find a staff member to assist Resident #100 and had not yet communicated Resident #100's request to the nursing staff.In an observation and interview on 3/31/26 at 11:44 AM, Certified Nursing Assistant (CNA) EE entered Resident #100's room to deliver her lunch tray. Noted that when CNA EE arrived to Resident #100's room, the resident removed her soiled brief and threw it on the floor. Observed CNA EE prepare supplies and provide incontinence care for Resident #100 at this time. Observed Resident #100 appeared distressed and was moving around frequently in bed stating .diaper . repeatedly. CNA EE reported she was not assigned to Resident #100 and was not aware that Resident #100 had previously requested a brief change. Noted Resident #100 had been incontinent of bowel, and her linens were visibly soiled. Observed Resident #100 as she stated .my butt hurts . to CNA EE. Observed CNA EE provide incontinence care, and noted Resident #100 became agitated and aggressive several times during care. Noted dried bowel movement on Resident #100's bilateral buttocks that required additional soaking/washing to remove. Due to Resident #100's agitation/aggressive behaviors, Social Worker RR came to assist with redirecting Resident #100 and providing reassurance for the remainder of Resident #100's incontinence care.In an interview on 3/31/26 at 4:22 PM, Interim Director of Nursing (DON) B reported when responding to an activated call light, staff should leave the light on if the need is not able to be immediately addressed.Review of the policy/procedure Routine Resident Care, dated 3/12/25, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed .Residents receive the necessary assistance to maintain good grooming and personal/oral hygiene .Incontinence care is provided timely according to each resident's needs .Resident's call lights are answered timely and resident's requests are addressed, if permitted .Review of the policy/procedure Call Lights, dated 3/12/25, revealed .Call lights will be placed within the resident's reach and answered in a timely manner .Responding to a Call Light .Identify the location and answer the resident promptly .Knock on the door, identify yourself and ask the resident what you can help them with .Go to the location of the call light, and turn off the light if you are able to meet the resident request .Do what the resident requests of you, if permitted. If you are unsure go ask the charge nurse .When finished, turn the call light off and replace the call light within resident's reach .

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. This citation pertains to Intake # 2792486 & 2793260.Based on interview, and record review, the facility failed to ensure facility staff provided care that maintains the highest practicable physical and mental well-being for residents with dementia, cognitive deficit, and behaviors in 1 of 6 residents (Resident #100) reviewed for dementia care, resulting in agitation, distress, resistance to care, and the potential for additional care refusals.Findings include:Resident #100Review of an admission Record revealed Resident #100 was a female, with pertinent diagnoses which included heart failure, insomnia, post-traumatic stress disorder, bipolar disorder, dementia, anxiety, obstructive lung disease, arthritis, a history of falls, and hearing loss.Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 2/9/26, revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, indicating she had severe cognitive impairment.Review of a current Care Plan for Resident #100 revealed the need .has impaired communication r/t (related to) Hearing loss . revised 10/6/23, with interventions which included .Speak clearly and distinctly, adjusting volume and tone as needed . initiated 3/20/23.Review of a current Care Plan for Resident #100 revealed the need .at risk for decline in cognition and has impaired cognitive function or impaired thought processes R/T (related to): Dementia . revised 4/22/25, with interventions which included .Use communication techniques to enhance interaction: Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from the resident, to ensure understanding, Face when speaking and make eye contact, Turn off TV/radio as needed to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and picture . and .Utilize approaches which allow resident to engage in activities such as limiting choices, cueing/reorientation, task segmentation, simple instructions/ activities that avoid overly demanding tasks, present one thought at a time, ask yes/no questions in order to determine resident's needs . both initiated 8/14/23.Review of a current Care Plan for Resident #100 revealed the need .has the potential for fluctuations in mood R/T: DX (Diagnosis): Bipolar DO (Disorder), Major Depression, Anxiety, Dementia becomes anxious and accusatory towards others i.e. forgets when she took pain medication and becomes accusatory (and) behavioral, unable to locate personal belongings and believes someone took them. Is profoundly hard of hearing (and) makes it difficult for her to understand when attempting to explain/redirect . revised 12/3/23, with interventions which included .Approach in a calm, quiet manner. Maintain appropriate body language during interactions such as maintaining eye contact and sitting in a relaxed position . initiated 4/17/23.In an interview on 3/25/26 at 3:54 PM, Certified Nursing Assistant (CNA) DD reported she assisted Resident #100 with incontinence care on 1/22/26, during the early morning hours (at approximately 3:00 AM), with the assistance of Licensed Practical Nurse (LPN) M. CNA DD reported they had approached Resident #100 to complete incontinence care several other times earlier in the shift, however, Resident #100 was combative and refused incontinence care during those previous attempts. CNA DD reported Resident #100 had not had her brief changed since around dinner time the evening prior due to the refusals/combative behaviors. CNA DD stated .We had to at least attempt to change her . CNA DD reported when she and LPN M went in to assist Resident #100 with incontinence care, LPN M pulled her covers back and Resident #100 started .trying to hit and kick . CNA DD reported LPN M held Resident #100's hands so they (CNA DD and LPN M) wouldn't get hit, and she changed Resident #100's wet brief. CNA DD reported after a few moments, Resident #100 stopped resisting care and said .OK I quit . and allowed CNA DD to complete the incontinence care.In an interview on 3/26/26 at 9:27 AM, Licensed Practical Nurse (LPN) R reported she was Resident #100's assigned nurse on 1/22/26 for day shift. LPN R reported she went into Resident #100's room on 1/22/26 in the morning to complete her rounds, and as LPN M walked by the door Resident #100 (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told LPN R to not let him (LPN M) in the room because LPN M had grabbed her arm. LPN R reported she observed a bruise on Resident #100's left arm. LPN R stated .She (Resident #100) was frightened .She is usually not afraid . LPN R reported Resident #100 has a history of refusing care, and if staff keep trying, she will often become more combative. LPN R reported when Resident #100 becomes combative, staff are to step away and give her space to calm down before re-approaching. LPN R stated .sometimes all it takes is a different person to approach her . and she will accept care. LPN R reported Resident #100 is not good at communicating her needs vocally and has impaired hearing. In an interview on 3/26/26 at 11:20 AM, CNA U reported she has worked with Resident #100 previously, and how staff approach her plays an important role in the way she reactions. CNA U reported sometimes Resident #100 will accept care and sometimes she .freaks out . CNA U reported when that happens, staff will give her space and re-approach at a different time.In an interview on 3/26/26 at 1:07 PM, CNA EE reported she has worked with Resident #100 previously, and reported Resident #100 can be resistant to care. CNA EE stated if Resident #100 doesn't want staff to change her, they give her space and re-approach at a different time, stating .I don't poke the bear . CNA EE reported she will sometimes try and find a different staff member who has known Resident #100 longer to re-approach and offer care. CNA EE reported they are usually able to find someone to calm Resident #100 down enough to allow care to be completed.In an interview on 3/26/26 at 4:27 PM, CNA GG reported she worked with Resident #100 on 1/21/26, and the resident had been refusing incontinence care throughout the evening. CNA GG reported when approached for incontinence care, Resident #100 began attempting to hit and swing at staff, so she left and re-approached later with another CNA. CNA GG reported those behaviors continued, so they decided to give the resident some space. CNA GG reported when third shift arrived, she notified CNA DD and LPN M that she was unable to change Resident #100's brief that evening and that Resident #100 was refusing care. CNA GG reported LPN M made a statement that Resident #100 had to be changed, and it didn't matter if she didn't want to. CNA GG reported she went into the room with CNA DD and LPN M and again, Resident #100 started kicking, swinging, and refusing incontinence care. CNA GG reported incontinence care was not provided at that time, and she completed her shift. CNA GG reported when she returned a few days later, she observed oval-shaped bruising on one of Resident #100's forearms.In an interview on 3/30/26 at 4:06 PM, LPN M reported he was Resident #100's assigned nurse from 1/21/26 to 1/22/26 on third shift. LPN M reported he did not receive any information in report regarding Resident #100 being combative or refusing care. LPN M reported as the shift progressed, the CNAs reported that Resident #100 was being combative and refusing to have her brief changed. LPN M reported they tried different caregivers and re-approaching her and stated .I couldn't just leave her like that . LPN M reported he went to the room to assist CNA DD with incontinence care later in the shift and attempted to softly wake Resident #100. LPN M reported CNA DD started to change Resident #100's wet brief and that is when Resident #100 became combative. LPN M reported he held Resident #100's hands/arms for a brief period of time to keep him and CNA DD from being struck, and once Resident #100 realized it was him (LPN M) she stopped resisting and allowed CNA DD to complete incontinence care. LPN M reported Resident #100 was .half-asleep . when they began attempting to change her wet brief. LPN M reported there were no further issues or complaints involving Resident #100 for the remainder of his shift. LPN M reported when residents refuse care, staff attempt to re-approach at a later time or get a different staff member to approach and offer care. LPN M reported he is now aware that when the resident became combative, he should not have intervened.In an interview on 3/31/26 at 10:43 AM, LPN Q reported she had worked with Resident #100 previously and indicated that when the resident refuses care and becomes combative, staff should give her space and re-approach at a later point in time. LPN Q stated .She might be nice as pie. You have to be cautious because she will just as quickly turn around and start screaming at you and hitting you .In an interview on 3/31/26 at 12:17 PM, Unit Manager D reported Resident #100 has a history of being combative with care. Unit Manager D reported she was notified on 1/22/26 that Resident #100 was complaining of pain in her (continued on next page)

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	235483	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Galesburg	1080 N 35th Street Galesburg, MI 49053

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arm. Unit Manager D reported she talked with Resident #100 and observed new bruising on one arm. Unit Manager D reported when asked what happened, Resident #100 reported staff changed (her brief) when she did not want to be changed. Unit Manager D reported when Resident #100 is resistant to care, staff have been instructed to get a second staff member for assistance. Unit Manager D reported if there is not an immediate safety risk and the resident is refusing care, staff should give her space and re-approach at a later point in time. Unit Manager D reported sometimes staff are able to distract Resident #100 with conversation or a snack. Unit Manager D reported after the incident involving Resident #100 on 1/22/26, staff were educated to re-approach when Resident #100 refuses care, offer the resident snacks, and make sure the resident is more fully awake before initiating care .because maybe that startled her .In an interview on 1/31/26 at 2:33 PM, Assistant Director of Nursing (ADON) E reported on 1/22/26 Resident #100 complained of arm pain and alleged that a male staff member had hurt her arm. ADON E reported they obtained X-rays and the results were normal, with no fracture or soft tissue swelling identified. ADON E reported Resident #100 had bruising on her left forearm that was dark purple in color and complained of pain in her left arm. ADON E reported Resident #100 has a history of combative behaviors and resistance to care and gets bruises often due to flailing her arms and swinging at staff during care. ADON E stated .She can really be aggressive . ADON E reported after the incident/allegations on 1/22/26 involving Resident #100, staff were educated on resident rights, including the right to refuse care, and resident safety. ADON E reported when residents have these kinds of behaviors (combativeness/resistance to care) how staff approach them is important. ADON E reported staff were educated to have someone talk with the resident as a distraction while other staff provide care. ADON E stated .Don't just say this has got to be done . ADON E reported it was important to weigh the risks/benefits of each situation and determine .what keeps the patient the safest .If they tell you to leave, leave .In an interview on 3/31/26 at 3:17 PM, Social Worker RR reported Resident #100 has a history of combative behaviors and refusing care, and stated .despite her small size she is mighty . Social Worker RR reported these behaviors can be elevated when the resident is not familiar with a staff member. Social Worker RR reported after the incident on 1/22/26 involving Resident #100, staff were educated to give the resident space when she becomes combative, re-approach at a later point in time, and offer different caregivers. Social Worker RR stated .You have to allow her to de-escalate. You have to leave her alone . Social Worker RR reported these care refusals and aggressive behaviors are related to her mental health diagnoses and diagnosis of dementia.Review of the policy/procedure Behavior Management, dated 4/20/23, revealed .The facility will provide individualized care and services that promote the highest practicable level of function by providing activity/functional programs as appropriate and safety interventions to minimize behaviors .It is essential that behaviors are recognized as a form of communication, rather than as a random, unpredictable or meaningless event. Attempting to identify causes of behaviors will assist with developing the appropriate plan, with appropriate interventions, to respond to these behaviors .Certain behavior may be anticipated and sometimes may be preventable based on understanding the underlying causes and possible triggers for each individual .The facility staff will utilize tasks in PCC (electronic medical record system) to document behaviors exhibited by the resident, including new, existing and escalating behaviors, as well as the effectiveness of interventions. Additional documentation may be needed in the IDT (Interdisciplinary Team) progress, behavior notes and at-risk notes regarding the behavior, interventions and changes to plan of care .Attempt to identify possible risk and causal/contributing factors for behaviors such as .Fatigue, lack of sleep or change in sleep patterns which may make the person more likely to misinterpret environmental cues resulting in anxiety, aggression or confusion .Sensory deficits (hearing, sight, smell) .The IDT will implement a care plan with the resident and/or resident representative or update existing care plan, with interventions that target behavioral symptoms, identified causes, resident specific goals and resident specific behaviors .Behavior care plans will be established for those with behaviors related to dementia, mental illness or other needs (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Interventions will include specific non-pharmacological interventions and behavior management strategies developed specifically for the resident .During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included assessment of all residents and education on resident rights for refusal of care. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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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. This citation pertains to Intake # 2792486 & 2793260.Based on interview, and record review, the facility failed to ensure a complete and accurate medical record in 1 of 13 residents (Resident #100) reviewed for comprehensive/accurate medical records, resulting in incomplete/missing charting related to resident behavioral concerns and skin alterations, the potential for additional behaviors to go unaddressed, and an inaccurate portrayal of resident status.Findings include:Resident #100Review of an admission Record revealed Resident #100 was a female, with pertinent diagnoses which included heart failure, insomnia, post-traumatic stress disorder, bipolar disorder, dementia, anxiety, obstructive lung disease, arthritis, a history of falls, and hearing loss.Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 2/9/26, revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, indicating she had severe cognitive impairment.In an interview on 3/25/26 at 3:54 PM, Certified Nursing Assistant (CNA) DD reported she assisted Resident #100 with incontinence care on 1/22/26, during the early morning hours (at approximately 3:00 AM), with the assistance of Licensed Practical Nurse (LPN) M. CNA DD reported they had approached Resident #100 to complete incontinence care several other times earlier in the shift, however, Resident #100 was combative and refused incontinence care during those previous attempts. CNA DD reported Resident #100 had not had her brief changed since around dinner time the evening prior due to the refusals/combative behaviors. CNA DD stated .We had to at least attempt to change her . CNA DD reported when she and LPN M went in to assist Resident #100 with incontinence care, LPN M pulled her covers back and Resident #100 started .trying to hit and kick . CNA DD reported LPN M held Resident #100's hands so they (CNA DD and LPN M) wouldn't get hit, and she changed Resident #100's wet brief. CNA DD reported after a few moments, Resident #100 stopped resisting care and said .OK I quit . and allowed CNA DD to complete the incontinence care.In an interview on 3/26/26 at 9:27 AM, Licensed Practical Nurse (LPN) R reported she was Resident #100's assigned nurse on 1/22/26 for day shift. LPN R reported she went into Resident #100's room on 1/22/26 in the morning to complete her rounds, and as LPN M walked by the door Resident #100 told LPN R to not let him (LPN M) in the room because LPN M had grabbed her arm. LPN R reported she observed a bruise on Resident #100's left arm. LPN R stated .She (Resident #100) was frightened .She is usually not afraid . LPN R reported Administrator A directed her to monitor the bruise on Resident #100's arm. LPN R reported she did not document her observation of the bruise on Resident #100's arm because .I didn't know what (Administrator A) wanted me to do .In an interview on 3/30/26 at 4:06 PM, LPN M reported he was Resident #100's assigned nurse from 1/21/26 to 1/22/26 on third shift. LPN M reported he did not receive any information in report regarding Resident #100 being combative or refusing care. LPN M reported as the shift progressed, the CNAs reported that Resident #100 was being combative and refusing to have her brief changed. LPN M reported they tried different caregivers and re-approaching her and stated .I couldn't just leave her like that . LPN M reported he went to the room to assist CNA DD with incontinence care later in the shift and attempted to softly wake Resident #100. LPN M reported CNA DD started to change Resident #100's wet brief and that is when Resident #100 became combative. LPN M reported he held Resident #100's hands/arms for a brief period of time to keep him and CNA DD from being struck, and once Resident #100 realized it was him (LPN M) she stopped resisting and allowed CNA DD to complete incontinence care. LPN M reported Resident #100 was .half-asleep . when they began attempting to change her wet brief. LPN M reported there were no further issues or complaints involving Resident #100 for the remainder of his shift. LPN M reported when residents refuse care, staff attempt to re-approach at a later time or get a different staff member to approach and offer care. LPN M reported he did not document the pattern of incontinence care refusals or the combative behaviors displayed by Resident #100 during that shift. LPN M reported he is now aware that he should have documented the refusals (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within Resident #100's electronic medical record.Review of the Progress Notes for Resident #100 revealed no documentation of her care refusals or combativeness with care on 1/21/26 and 1/22/26 (during third shift).In an interview on 3/31/26 at 10:43 AM, LPN Q reported she had worked with Resident #100 previously and indicated that when the resident refuses care and becomes combative, staff should give her space and re-approach at a later point in time. LPN Q stated .She might be nice as pie. You have to be cautious because she will just as quickly turn around and start screaming at you and hitting you . LPN Q reported when a resident refuses care or becomes combative during care, this behavior should be documented by the CNAs in the behavioral charting, and in a progress note if the nurses are aware.In an interview on 3/31/26 at 12:17 PM, Unit Manager D reported Resident #100 has a history of being combative with care. Unit Manager D reported she was notified on 1/22/26 that Resident #100 was complaining of pain in her arm. Unit Manager D reported she talked with Resident #100 and observed new bruising on one arm. Unit Manager D reported when asked what happened, Resident #100 reported staff changed (her brief) when she did not want to be changed. Unit Manager D reported when Resident #100 is resistant to care, staff have been instructed to get a second staff member for assistance. Unit Manager D reported if there is not an immediate safety risk and the resident is refusing care, staff should give her space and re-approach at a later point in time. Unit Manager D reported sometimes staff are able to distract Resident #100 with conversation or a snack. Unit Manager D reported after the incident involving Resident #100 on 1/22/26, staff were educated to re-approach when Resident #100 refuses care, offer the resident snacks, and make sure the resident is more fully awake before initiating care .because maybe that startled her . Unit Manager D reported CNAs should document behaviors (such as care refusals and combative behaviors) in the alert charting, and nursing should document behaviors and care refusals in the progress notes.In an interview on 1/31/26 at 2:33 PM, Assistant Director of Nursing (ADON) E reported on 1/22/26 Resident #100 complained of arm pain and alleged that a male staff member had hurt her arm. ADON E reported they obtained X-rays and the results were normal, with no fracture or soft tissue swelling identified. ADON E reported Resident #100 had bruising on her left forearm that was dark purple in color and complained of pain in her left arm. ADON E reported Resident #100 has a history of combative behaviors and resistance to care and gets bruises often due to flailing her arms and swinging at staff during care. ADON E stated .She can really be aggressive . ADON E reported after the incident/allegations on 1/22/26 involving Resident #100, staff were educated on resident rights, including the right to refuse care, and resident safety. ADON E reported when residents have these kinds of behaviors (combativeness/resistance to care) how staff approach them is important. ADON E reported staff were educated to have someone talk with the resident as a distraction while other staff provide care. ADON E stated .Don't just say this has got to be done . ADON E reported it was important to weigh the risks/benefits of each situation and determine .what keeps the patient the safest .If they tell you to leave, leave . ADON E reported behaviors such as combativeness and refusing care should be documented by the CNAs in the clinical alerts, and by nursing staff in the progress notes.In an interview on 3/31/26 at 3:17 PM, Social Worker RR reported Resident #100 has a history of combative behaviors and refusing care, and stated .despite her small size she is mighty . Social Worker RR reported these behaviors can be elevated when the resident is not familiar with a staff member. Social Worker RR reported after the incident on 1/22/26 involving Resident #100, staff were educated to give the resident space when she becomes combative, re-approach at a later point in time, and offer different caregivers. Social Worker RR stated .You have to allow her to de-escalate. You have to leave her alone . Social Worker RR reported these care refusals and aggressive behaviors are related to her mental health diagnoses and diagnosis of dementia. Social Worker RR reported she would expect to see documentation related to care refusals and combative behaviors within the electronic medical record by the nursing and CNA staff.Review of the policy/procedure Behavior Management, dated 4/20/23, revealed .The facility will provide individualized care and services that promote the highest practicable level of function by providing activity/functional programs as (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate and safety interventions to minimize behaviors .The facility staff will utilize tasks in PCC (electronic medical record system) to document behaviors exhibited by the resident, including new, existing and escalating behaviors, as well as the effectiveness of interventions. Additional documentation may be needed in the IDT (Interdisciplinary Team) progress, behavior notes and at-risk notes regarding the behavior, interventions and changes to plan of care .Review of the policy/procedure Documentation Expectations, dated 6/21/23, revealed .Healthcare personnel will complete documentation requirements as outlined by the company and recorded in the medical record using accepted principles of documentation .Aspects of resident care such as observations and assessments, administration of medications, and services or treatments performed must be documented in the resident medical record according to company policy .Be Complete. All facts and pertinent information related to an event, course of treatment, resident condition, response to care, and deviation from standard treatment (including the reason for the deviation) must be documented .