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	09/10/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide adequate supervision and implement interventions to prevent falls for 1 resident (Resident #7) of 6 residents, resulting in a fall, pain, and impaired functional ability due to amputation of right long finger and injury to right ring fingers. Findings include: Resident #7: Review of an admission Record revealed Resident #7 was a male with pertinent diagnoses which included dementia, history of falling, anxiety, adjustment disorder, hallucinations, legal blindness, hearing loss right ear, and restless leg syndrome (irresistible urge to move the legs). Review of current Care Plan for Resident #7, revised on 7/10/2018, revealed the focus, .(Resident #7) is at risk for fall related injury and falls R/T (related to): impaired gait, impaired mobility, muscle weakness, impaired vision and impaired hearing, resident has hallucinations. with the intervention .Anti roll backs to w/c (wheelchair) Initiated: 08/25/2022.Therapy to eval for wheelchair and safety evaluation.Date Initiated: 11/04/2024.AMBULATION/WALKING: Resident is unable to ambulate and requires max assistance with ambulation.Date Initiated: 02/24/2025.TRANSFER: Substantial/maximal assistance) with two helper(s).Date Initiated: 02/24/2025.Review of Progress Note dated 4/29/25 at 00:00 AM, revealed, .XXX[AGE] year-old male is seen today due to staff report that he had a fall. He was noted to have slid out of his wheelchair while sitting at the nurses station. He was not noted to have any injuries at this time.History is limited d/t patient mental status.ASSESSMENTS AND PLANS.New dycem (reusable non-slip material used to hold objects in firmly in place) has been placed in his wheelchair and therapy will assess for new cushion to encourage resident to sit back in his wheelchair.Review of Resident At Risk dated 4/29/2025 at 10:30 AM, revealed, .Reviewed Clinical Indicator: High risk for falls secondary to dementia, hallucinations, legally blind, HOH (hard of hearing), leans forward when propelling wheelchair and history of falls.Action Taken: New dycem placed in chair. OT (Occupational Therapy) to evaluate for wedge cushion in wheelchair.Response to Previous Actions Taken: Nursing to monitor effectiveness of new actions.Review of Physical Device Evaluation dated 6/13/25, revealed, .Type of Device: 2. Self-Releasing Belt.Does the device meet the following criteria: 1. It is attached or adjacent to the resident.2. Cannot be easily removed by the resident (cannot be removed intentionally).Met all 3 criteria, No. The device is an enabler.Reason for Enabler Device use: Repositioning/Support.Enable/Increase Bed Mobility.Enhance Mobility. Review of Nurses Notes dated 7/23/2025 at 11:15 AM, revealed, .(Specialty Care Unit) Nurse and UM were notified by PA (Physician Assistant) and CNAs (Certified Nursing Assistants) regarding (Resident #7)'s fall in the (Specialty Care Unit) Lounge. Upon assessment of the area, the table was turned over, and (Resident #7) was lying on his right side, responsive to verbal stimuli. VS (vital signs) 132/67, 62, 97.8, 14, 95%. Amputation of the 4th digit of his right hand, and skin removed on the 3rd digit. A pressure dressing was applied with moist gauze to the right digits and wrapped with Kerlex gauze. 911 was called to transfer (Resident #7) to (Local Hospital) . Review of Nurses Notes dated 7/23/2025 at 8:20 PM, revealed, .Res returned from (Local hospital). Res has an amp (amputation) of the right fingertip. New order for Keflex 500 mg 2 times a day for 7 days . Review of Care Plan dated 02/24/25, revealed, the (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	focus .(Resident #7) has a functional ability deficit and requires assistance with self care/mobility . with the intervention .AMBULATION/WALKING: Resident is unable to ambulate and requires max assistance with ambulation. (Resident #7) will attempt to transfer himself.Revision on: 07/16/2024. Review of Incident Report dated 7/23/25, revealed, .Incident Description: Nursing Description: (Specialty Care Unit) Nurse and UM (Unit Manager) were notified by PA (Physician Assistant) and CNAs regarding (Resident)'s fall in the (Specialty Care Unit). Upon assessment of the area, the table was turned over, and (Resident #7) was lying on his right side, responsive to verbal stimuli. VS (vital signs) 132/67, 62, 97.8,14, 95% .Was this incident witnessed: N .Immediate Action Taken: Description: Amputation of the 4th digit of his right hand, and skin removed on the 3rd digit. A pressure dressing was applied with moist gauze to the right digits and wrapped with Kerlex (high absorbency, crinkle weave pattern cushions and protects wounds) gauze .911 was called to transfer (Resident #7) to (Local Hospital), wheelchair inspected, wheel cover ordered to cover wheels, seatbelt removed, care plan updated, guardian notified, provider bedside .Notes: Resident had amputation of 3rd & 4th digit of the right hand, bruising / redness of face, shoulders and lower extremities, and right hand .Injury Report Post Injury: Skin tear .27. Right hand (palm), Wheelchair brakes unlocked .Confused, Gait Imbalance .Ambulating without assistance . Review of summary of Staff Interviews revealed, .Certified Nursing Assistant (CNA) CC: Provided care for (Resident #7) at 650 AM, put seatbelt on, took to hallway at nurse's station. Resident placed in fish room (Resident Lounge) for meal unsupervised .Unit Manager (UM) C: notified by CNA that (Resident #7) had a fall in sensory/lounge. (Physician Assistant) was present, assessed resident. Noticed severed fingertip, on right finger, Right side and right ring finger skin tear. Sent to (Local Hospital) after first aide.Physician Assistant (PA) EEE: At around 10:15 AM, I was at nursing station and heard a noise, then the table turned over (Resident #7) laying on right side, head toward wall - wheelchair was turned opposite from resident, provided first aide and assessed resident, fingertip was behind the wheelchair.Licensed Practical Nurse (LPN) N: This morning at breakfast, CNA moved resident to lounge for breakfast, around 07:30 AM, At 10:15 AM (UM C) helped me restock narcotics when another nurse notified fall. Table was tipped over. Noticed fingertip was severed, provided assessment, LOC (level of consciousness) normal, provided first aide, call 911.CNA O: Took over at 08:30 AM care for (Resident #7), At 08:30 AM (Resident #7) was in lounge.(CNA CC) stated she had toileted him prior to leaving. The last time I checked on resident at 09:30 and he was sitting at table in the lounge. Was sitting charting at 10:15 AM, and (PA EEE) was standing in front of nurse station and informed about fall. Resident was laying on his side and table was flipped over. Resident was incontinent of diarrhea, was still having active BM (bowl movement) while on the floor. Nurse assessed/PA evaled, 911 called.Review of Physician Assistant Progress Note from (Local Hospital) dated 8/5/25, revealed, .Diagnosis: 1. Injury of finger of right hand, subsequent encounter.2. Laceration of right hand without foreign body, subsequent encounter.HPI: (Resident #7) is a 82 y.o. male with history of blindness and severe hearing loss who presents today for follow up of a right hand injury sustained 13 days ago when he fell out of his wheelchair and his long and ring fingers were caught in the wheelchair. Patient was evaluated at the ER where imaging showed a comminuted fracture of the distal fourth phalanx. He had a revision amputation with nail bed removal of right ring finger and I&D (Irrigation and Debridement) with repair of damaged fractures of right long finger by the ortho resident. He was placed in a cast last visit since he immediately began taking dressing off. He is accompanied by (Staff) from his LTC facility who helps provide history.Placed in three finger ulnar gutter cast (cast use to immobilize fractures) for protection .In an interview on 09/09/2025 at 11:33 AM, Licensed Practical Nurse (LPN) N reported she heard a loud noise, and Resident #7 had fallen out of his wheelchair and the table was turned on its side. LPN N demonstrated where the table was located midway along the wall on the right, the resident was lying on his right side near the table and the wheelchair was on the other side of the resident by his feet on the other side of the room. LPN N reported this event happened shortly after breakfast and he was in here eating his breakfast. LPN N reported at the time of the incident, he was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	ambulatory, up to the bathroom with assistance, no seatbelts anymore as a restraint, and he had occasions of restless and anxiousness. LPN N reported Resident #7 was unaware of his strength level. LPN N reported he does have periods of incontinence. LPN N reported the best guess was Resident #7 had a period of incontinence, went to stand up out of his wheelchair, had his fingers in the spokes of his wheelchair, the wheelchair rolled back and that was how the injury occurred. LPN N reported when she initially responded he was laying on his right side, wheelchair had rolled away, and he had a traumatic injury. In an interview on 09/09/2025 at 11:48 AM, Unit Manager (UM) C reported he was restocking in the (narcotic box) system and the door to the room was open. UM C reported there was a loud noise, one of the CNAs reported Resident #7 had fallen out of his chair. UM C reported himself and LPN N responded to the room (lounge) and he was lying on his right side, he was in a fetal position and portion of his finger lying on the floor. UM C reported LPN N went and retrieved a plastic bag and placed the finger on ice. UM C reported the table was upright, unsure of where the wheelchair was located, reported Resident #7 was facing the window at the back wall. UM C reported vitals signs were taken, first aide to his hand - placed moist gauze and kerlex to act as a kind of pressure bandage. UM C reported 911 had been called and the staff monitored his hand, reported Resident #7 was alert and talking to staff. UM C reported emergency services arrived and took him to the local hospital. UM C reported Resident #7 ended up having surgery where they removed more of his finger and closed the tip of it up. UM C reported the tip of Resident #7's finger was behind him and it was a ways from him. UM C reported Resident #7 could stand with direction and staff with him. UM C reported Resident #7 was able to walk to bathroom, 3-4 feet, prior to the fall. UM C reported the current chair Resident #7 had was prescribed by hospice as he was recently placed on hospice services. UM C reported it was a larger broda chair to accommodate Resident #7's size, reported the chair reduced his ability to self-propel. UM C reported Resident #7 wanted to always stand up. In an interview on 09/10/2025 at 9:20 AM, Activity Aide (AA) HH reported Resident #7 did attempt to get up from his wheelchair a lot. AA HH reported he was placed in the lounge to eat his breakfast as he kept pushing the dining room table in the dining room. In an interview on 09/10/2025 at 11:36 AM, CNA O reported she was sitting at the nurse's station on the computer charting on residents. CNA O reported she was informed he had been toileted prior to the aide leaving to go to another unit. CNA O reported the other aide had placed him in that room, to eat his breakfast there. CNA O reported she did not see what had happened but heard the noise, ran into the room, the table was flipped over, noticed he had a bowel movement, went to get clothing and other items to clean him up. CNA O reported Resident #7 was crying out, staff asked him if his finger hurt, and she placed a towel under his head. CNA O reported the nurse was assessing him and performing first aide on Resident #7. CNA O reported Resident #7 would stand up a lot and the seat belt was to remind him he couldn't stand up without it being unbuckled. CNA O reported Resident #7 was brought to the lounge to eat his breakfast and he did better sitting at the table in there as when he was in the dining room he would be reaching out to find items on the table and would touch other resident's food and other items and those residents would get upset. During an observation on 09/08/2025 at 1:03 PM, Resident #7 was observed in the hallway, his head was reclined back almost flat, approximately 20 degrees, the footrest was up at the level of his head, and his bottom was dipped down in the seat which did not allow Resident #7 to rise up from the chair on his own. Review of Therapy Note dated 7/30/2025 at 1:15 PM, revealed, .(Resident #7) was placed in a new 20-inch wheelchair with (B) spoke covers added to wheels, pressure reducing cushion with dycem on top, (B) rear anti-tippers, and anti-rollback self-locking brakes. In an interview on 09/09/25 at 11:44 AM, Rehab Manager JJ reported Resident #7 was assessed and started service on 5/12/25 and therapy trialed restraint reduction and Resident #7 needed all the interventions on his wheelchair; such as a cushion, anti-rollbacks, and anti-tippers. Rehab Manager JJ reported the seated belt notified the staff when Resident #7 was getting fidgety. Review of Nurses Notes dated 8/5/2025 at 12:22 PM, revealed, .Resident was restless and made multiple attempts at standing and exiting the wheelchair. LPN instructed CNA to please toilet the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	resident again to follow the care plan. Resident did not void and was becoming agitated in the bathroom and stated he did not have to void. Resident was returned to wheelchair and sat in front of the nurses station for monitoring. Non-pharm interventions for anxiety/agitation included a calm approach, providing a meal, toileting, conversation, and brief check. Review of Incident Report dated 8/6/25 at 11:30 AM, revealed, .CNAs (CNA P), (CNA CC) and (Unit Manager) were attempting to ambulate 3.5 feet to his toilet. We were able to assist (Resident #7) just in front of the toilet when he started collapsing, and he was lowered to the floor without hitting his head.This writer assessed (Resident #7) and he did not have any obvious injuries, and since it was witnessed, he was assisted to his feet and subsequently toileted.The addition of another CNA was needed to get (Resident #7) to his feet.Note: No immediate intervention was put in place to ensure safety immediately. Review of Care Plan for Resident #7 revised on 08/8/25, revealed the focus, .(Resident #7) is at risk for fall related injury and falls R/T (related to): impaired gait, impaired mobility, muscle weakness, impaired vision and impaired hearing, resident has hallucinations. with the intervention .Use bedside commode for safety. This writer had multiple observations of no commode present in Resident #7's room from 09/08/25 - 09/10/25. In an interview on 09/10/2025 1:06 PM, Director of Nursing (DON) B reported Resident #7 had a fall and amputated part of his finger. DON B reported Resident #7 was placed on hospice services after his return. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included education to all staff, monitoring of the noncompliance that includes feedback from the Quality Assurance committee. The facility was able to demonstrate monitoring of the corrective action and maintained compliance. Compliance date of 7-28-25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain best practices in accordance with professional standards of food service safety. The deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen.Findings include: On 9/8/25 at 10:07 AM, Observation of the of the two door [NAME] cooler found a tub of nourishment shakes and snacks used for tray line and dated for a week at a time. Further observation found half a dozen magic cups inside of the tub with manufacturer's directions that state the items need to be consumed within five days under refrigeration. On 9/8/25 at 10:50 AM, A tour of the activity rooms pantry refrigerator and resident refrigerator, with Dietary Manager (DM) KK, found the following items: two unopened yogurts with best by dates of 31 [DATE], an unopened manufactured container stating it was a chicken bowl with a best by date of [DATE], a container of vanilla pudding with a best by date of 15 [DATE], a Tupperware container of chili with no name and date of 8-26, three milk cartons with best by dates of 30 [DATE], and two ready whip containers with use by dates of July 17th 2025. At this time, an interview with DM KK found that the activities department takes care of the resident fridge and the kitchen staff stock and check the pantry fridge. 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 . According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . On 9/8/25 at 10:19 AM, Observation of [NAME] DDD found that he was prepping raw chicken to be cooked for lunch. At this time, three sheet pans of chicken were laid out of the preparation table. After laying out the chicken, [NAME] DDD was observed adding spices to the chicken with the same gloves that were used to place the chicken on the sheet pans. The gloves were visibly wet and greasy from handling the raw chicken as [NAME] DDD started going through spices, picking up their original containers and spreading the spices over the chicken. When asked if he should be using the same gloves to handle raw chicken as he would to handle the spice containers, [NAME] DDD stopped what he was doing, discarded his gloves, and washed his hands. On 9/8/25 at 12:14 PM, Observation of [NAME] DDD on the serving line for lunch found he used his bare hands to grab a hamburger bun to make a cheeseburger for a resident. [NAME] DDD then put gloves on to grab a slice of cheese and add it to the cheeseburger. When asked if he normally wore gloves on the serving line to help complete task (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	specific items, such as assembling a burger, [NAME] DDD stated that they have been informed to not wear gloves while serving on the line. According to the 2022 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and:. (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; .(I) After engaging in other activities that contaminate the hands According to the 2022 FDA Food Code section 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12 (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. On 9/8/25 at 10:09 AM, Observation of the walk-in cooler found the back left rack showed increased accumulation of debris on the wire slats. An interview with DM KK found that they cleaned the racks recently but need to get that specific rack pulled out and power washed. Further observation found an accumulation of dirt and debris on the back floor juncture, in the corners, and near the legs of the storage racks. On 9/8/25 at 10:38 AM, An interview with DM KK found that Maintenance takes care of the ice machine cleanings and that a vendor had come in recently to go through both ice machines onsite. Observation of the kitchen ice machine found an accumulation of black debris on the corners of the inside plastic lip. When wiped with a clean paper towel, debris was evident and easily wiped off. Further review underneath and behind the kitchen ice machine and coffee area found an accumulation of dirt debris as well as plastic lids, plastic bags, and a nutritional cup (that requires refrigeration) underneath and against the wall.On 9/8/25 at 10:48 AM, Observation of the ice room outside of the kitchen found heavy accumulation of black spotted debris on the inside of the ice scoop holder. When shown to DM KK she stated she would get it cleaned. On 9/8/25 at 10:51 AM, Observation of the Activity fridge freezer found an increased accumulation of yellow debris and staining. Further observation of the Nourishment fridge found a heavy accumulation of dust and black spotted debris in the top gasket of the freezer and top portion of the refrigeration unit.On 9/8/25 at 11:04 AM, Observation of the dry storage room found increased accumulation of debris along the back floor and wall of the unit along with a handful of plastic spoons and a nutritional cup (that requires refrigeration). According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.

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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. Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility.Findings include:On 9/8/25 starting at 9:55 AM, an initial tour of the kitchen found three dead end water lines that came from the floor and were not connected to anything. These were located at the hand sink on the cook line, the three compartment sink, and the single compartment preparation sink. Further review of the kitchen found that the hot water handle was not on the faucet, not allowing for use or easy flushing of the water line. On 9/8/25 at 2:05 PM, An observation of the central bath found a spa tub surrounded with resident equipment and used for the storage of items. When asked if the tub is used, Maintenance Director (MD) CCC stated he had only been in the facility a few weeks and was unsure. When asked if this was something that gets flushed regularly, he was unsure. On 9/8/25 at 2:12 PM, Observation of the Skilled Hall soiled utility room found a hopper with no running water from the hopper spray or the hot side of the overhead faucet. When asked if this was flushed, MD CCC was unsure. On 9/8/25 at 2:21 PM, Observation of the [NAME] Hall shower room found three showers with two of the showers set up with items stored in the stalls, appearing to not be regularly used. When asked if the two shower stalls with items in them were used or flushed, MD CCC was unsure. On 9/8/25 at 2:25 PM, Observation of the [NAME] Hall soiled utility room found that the hot water on the overhead faucet was not turned on, indicating a stagnant line. On 9/8/25 at 2:43 PM, Observation of the Birch Hall weight room found a shower stall in the back left corner. When asked if the shower spray is something that gets flushed regularly MD CCC was unsure. On 9/8/25 at 2:48 PM, Observation of the Birch Hall soiled utility room found that brown and discolored water came out of the hot water fixture of the over hopper faucet. Further review found that the spray to the hopper was not turned on, indicating a stagnant line.A review of the facility provided documents with details of their Water Management Plan, found meeting minutes where only the previous Maintenance staff was present and no risk assessment with a written or visual display showing a description of the buildings water systems. A record review of the facility provided document entitled Water Management Program, revised 2/1/2024, found that, The general principles of an effective water management program include.Preventing water stagnation. Further review found that, The assessment will include a description of the building water systems using text and flow diagrams for identification, and that, The water management program team will meet quarterly in conjunction with the infection control committee to validate and verify the water management program utilizing the meeting minutes for the water management program.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to provide an environment that promoted a dignified dining experience for 5 residents (R#35, #39, #42, #57, and #7) of 5 residents reviewed for dignity, resulting in feelings of disappointment with the dining experiences. Findings include: During an observation on 09/09/25 at 5:01 PM, Dinner was being served on the Specialty Care Unit (SCU). During an observation of the meal cart, there were no other meals on the cart and staff reported more meals needed to be brought by the dietary staff. During this time frame, Residents #35, #39, #42, #57, and #7 did not have a meal tray or had waited for staff to assist with their meal. During an observation on 09/09/25 at 5:15 PM, another cart was brought to the SCU by dietary staff and nursing staff distributed the meals to the remaining residents who hadn't received their meals. Resident #35: Review of an admission Record revealed Resident #35 was a female with pertinent diagnoses which included dementia, aphasia (language disorder that affects a person's ability to communicate), anxiety, and confusion. Review of Review of a Minimum Data Set (MDS) assessment for Resident #35, with a reference date of 8/6/25, revealed, .Section GG: Eating: the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.Supervision or touching assistance.During an observation on 09/09/25 at 5:01 PM, Activities Aide (AA) HH was feeding the resident at the table with Resident #35. The resident she was assisting with her meal was almost finished with her meal. Resident #35 was looking around the room, looked at staff members who were in the dining room to see if they had her meal tray. During an observation on 09/09/25 at 5:09 PM, Resident #35's table mate was eating her dessert. Resident #35 was still looking around the room at staff looked to see if they had her meal tray for her. At 5:17 PM, Resident #35 received her meal tray. Resident #39:Review of an admission Record revealed Resident #39 was a male with pertinent diagnoses which included anemia (blood doesn't have enough red blood cells), dementia, pot-traumatic stress disorder (PTSD), Vitamin D deficiency, and mixed irritable bowel syndrome (abdominal pain, bloating, diarrhea, and constipation. Resident #42:Review of an admission Record revealed Resident #42 was a male with pertinent diagnoses which included traumatic brain injury, dementia, mild intellectual disabilities, seizures, and signs and symptoms concerning food and fluid intake. During an observation on 09/09/25 at 5:05 PM, Residents #39, Resident #42, and Resident #47 were seated at a table together. Resident #47 had his meal tray but, Resident #39 and Resident #42 did not have their meal trays. When the second cart arrived, Resident #39 and Resident #42 received their meal trays at approximately 5:16 PM. Resident #57:Review of an admission Record revealed Resident #57 was a male with pertinent diagnoses which included diabetes, dementia, kidney disease, GERD, edema, stroke, and anxiety. During an observation on 09/09/25 at 5:01 PM, Resident #57 had not received his meal tray, but his table mate did, and she was being assisted by a staff member with her meal. During an observation on 09/09/25 at 5:03 PM, Resident #57 asked for his dinner as he saw other residents had received their meal trays as well. During an observation on 09/09/25 at 5:15 PM, Resident #57 received his meal tray. Resident #57 was visibly upset and reported to staff he did not like anything that was served to him, and he proceeded to leave the room.Resident #7: Review of an admission Record revealed Resident #7 was a male with pertinent diagnoses which included dementia, legal blindness and hearing loss. During an observation on 09/09/25 at 5:07 PM, Resident #7's meal tray was in his room placed on his nightstand. Resident #7 was lying with his head in the opposite direction, and his meal was at his feet. His meal tray had been delivered to his room approximately 5:04 PM. At 5:22 PM, Resident #7 was assisted by staff with his meal. Certified Nursing Assistant (CNA) T was assisting him with his meal, and he had finished three bowls of food at this point and was working on his dessert. CNA T reported Resident #7 told her he was hungry and he meant it. In an interview on 09/10/2025 at 12:41 PM, CNA GG reported when delivering trays, you would make sure each resident seated at the same table had their meals at the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	same time as it was a dignity concern if residents had food and other residents seated at the table did not. CN GG reported it would be upsetting for the resident who didn't have their food to watch someone else eat when you were hungry as well. In an interview on 09/10/25 at 12:55 PM Director of Nursing (DON) B reported there were no early meals in the SCU. DON B reported there should be no reason there were two separate carts brought to the unit at different times for meal service. DON B reported all residents seated at a table should be served their meals together as it was a dignity concern for others to be eating when another resident did not have their meal as well.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a quiet homelike environment in resident areas at night as reported by 5 residents (Resident #15, Resident #54, Resident #33, Resident #79, Resident #20) of 18 residents reviewed for environment and as voiced in the confidential Resident Council Meeting resulting in resident dissatisfaction and frustration from constant noise levels.Findings include:Resident #15(R15) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R15 admitted to the facility on [DATE] with pertinent diagnoses including anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R15 was cognitively intact (13 to 15 cognitively intact). During an interview on 9/8/2025 at 10:50 AM, R15 stated that 3rd shift staff are loud and they don't care if they wake up residents. Resident #54 (R54) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R54 admitted to the facility on [DATE] with pertinent diagnoses including insomnia (sleep disorder characterized by difficulty falling or staying asleep). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R54 was cognitively intact (13 to 15 cognitively intact). During an interview on 9/8/2025 at 2:04 PM, R54 stated that 3rd shift staff are so inconsiderate since they slam doors and holler all night long. Resident #33 (R33) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R33 admitted to the facility on [DATE] with pertinent diagnoses including anxiety and insomnia (sleep disorder characterized by difficulty falling or staying asleep). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R33 was cognitively intact (13 to 15 cognitively intact). During an interview on 9/8/2025 at 11:51 AM, R33 stated that 3rd shift CNAs talk outside in the hall and are very loud and it disrupts his sleep. Review of Resident Council meeting notes dated 4/8/2025 revealed New business. night shift slamming doors. Review of Resident Council meeting notes dated 5/6/2025 revealed New business.3rd shift is slamming doors again. Review of Resident Council meeting notes dated 6/3/2025 revealed New business: 3rd shift slamming doors. During an interview on 9/9/2025 at 10:36 AM, Activity Director (AD) II said that she fills out any (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concern forms from resident council and gives them to Nursing Home Administrator (NHA) A to follow up on. During an interview on 9/9/2025 at 11:59 AM, NHA A stated that they are working hard on following up with concerns and looking at trends in their QAPI (Quality Assurance and Performance Improvement) meetings. NHA A said there were a few complaints about the noise levels a few months ago and he just received another concern form that morning regarding the noise levels on 3rd shift. Resident #79 Review of an admission Record revealed Resident #79 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: adjustment disorder and history of falling. Review of a Minimum Data Set (MDS) assessment for Resident #79, with a reference date of 7/29/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #79 was cognitively intact. In an interview on 9/8/25 at 9:45 AM., Resident #79 reported the staff was very loud during the night. Resident #79 reported it sounded like staff gathered outside of her door and talked and laughed while she was trying to sleep. Resident #79 reported she had difficulty sleeping and when the staff was loud at night, it made it harder. Resident #79 expressed that she was very tired this morning from being kept up last night because the staff was loud. Review of Care Plan for Resident #79 revealed Need/Goal/Interventions: . has alteration in sleeping pattern r/t (related to) dx (diagnosis) of insomnia (difficulty sleeping or staying asleep) . will obtain optimal amount of sleep.Attempt non-pharmacologic interventions to improve sleep patterns (Specify: create a quiet environment, comfortable temperatures.) With an initiated date of 1/24/2025. In an interview on 9/9/25 at 8:04 AM., Resident #79 reported she was woken up and kept up last night with the staff talking at the nurse's station again. Resident #79 reported it sounded like the staff was talking right outside of her door, it was very loud. It was noted that Resident #79's room was the closest room to the nurse's station. In an interview on 9/9/25 at 11:44 AM., Physical Therapy Assistant (PTA) VV reported Resident #79 had voiced concerns with staff being loud overnight and making it difficult for her to sleep. Resident #20 Review of an admission Record revealed Resident #20 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: obstructive sleep apnea (episodes of obstruction of the airway during sleep resulting in reduced or absent breathing), joint replacement surgery, and history of falling. Review of a Minimum Data Set (MDS) assessment for Resident #20, with a reference date of 8/7/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #20 was cognitively intact. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/8/25 at 9:56 AM., Resident #20 reported third shift (staff) did not have consideration for the residents and they were loud. Resident #20 reported she heard the staff when they were talking and laughing at the nurse's station, and it woke her up. Resident #20 reported she was furious and told the staff to shut up. Resident #20 reported she told PTA VV about how loud the staff was during the night. In an interview on 9/9/25 at 11:44 AM., PTA VV reported Resident #20 had told her that the staff was loud at night and they kept her up. PTA VV reported she told Director of Rehab (DOR) WW and Social Services (SS) PP about Resident #20's complaint regarding the staff being too loud on third shift. In an interview on 9/9/25 at 11:55 AM., DOR WW reported PTA VV did inform her of Resident #20's concern regarding noisy staff and she informed the other managers. Review of Guest Assistance Form for Resident #20 dated 9/8/25 revealed .Sunday 9/7 A.M. Approximately 5 AM staff @ (at) nurses' station were laughing & carrying on loudly & woke me up. In an interview on 9/9/25 at 3:36 PM., SS PP reported she has handled noise complaints in the past for facility residents. SS PP reported interventions she had used were to provide residents with ear plugs, closing doors, room moves, and education of staff to keep the noise levels down. SS PP reported she was not aware of any current noise concerns from any residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a complete and accurate medical record in 7 of 18 residents (Resident #47, #10, #69, #54, #9, #18, & #63) reviewed for comprehensive/accurate medical records, resulting in missing/inaccurate documentation and the potential for a deterioration in resident status. Findings include:Resident #47: Review of an admission Record revealed Resident #47 was a male with pertinent diagnoses which included Alzheimer's disease, dementia, psychotic disorder with hallucinations (mental illness causing a person to lose touch with reality, often perceiving this that aren't there), insomnia, altered mental status, and anxiety. Review of current Care Plan for Resident #47, revised on 6/2/25, revealed the focus, .(Resident #47) has a behavior program related to dementia diagnosis, history of hallucinations and delusions, has poor safety awareness, needs assistance with redirection at times . with the intervention .Assist resident to develop more appropriate methods of coping and interacting. Encourage resident to express feelings appropriately .Minimize potential for resident's disruptive behaviors by offering tasks which divert attention such as busy boards and snacks . Review of Resident #47's medical record from the period of 7/23/25 to 9/3/25 revealed multiple instances of undocumented observations of Resident #47 when he was assigned to be on one-to-one monitoring. On the dates, 7/25/25 - 7/26/25 the complete documentation for both days was missing from the record. In an interview on 09/10/2025 at 12:41 PM, Certified Nursing Assistant (CNA) GG reported it was important to complete the documentation for a one to one as the staff were assigned due to safety reasons to keep an eye on the resident. CNA GG reported you have to document and initial every 15 minutes on where the resident was located. In an interview on 09/10/2025 at 12:47 PM, Licensed Practical Nure (LPN) L reported when a resident was on one-to-one documentation it was the responsibility of the nurse to ensure the resident was being monitored and the nurse signed the document showing it was reviewed and completed. LPN L reported she maintained the 15-minute checklist with her at the cart or at the nurse's station. LPN L reported she was always walking up and down the hallways to deliver her medications or provide treatments and she would monitor residents as well. LPN L reported the report would need to be completed by the CNA assigned to him for that shift, by a CNA who monitored him while their CNA was on a break and by the nurse on the hallway. In an interview on 09/10/2025 at 1:01 PM, Director of Nursing (DON) B reported there should be no missing documentation for the 15-minute checklist and the nurse assigned to that resident should be double checking to ensure the staff were monitoring the resident and completing the checklist. DON B reported if the document was missing entries the facility can't ensure the resident's safety as not sure if the resident was monitored or was able to elope or had a fall. Review of Staff Meeting Script: Emphasizing Reporting and Documentation dated 5/30/25, revealed, .5. One to One Supervision: Purpose: The purpose of implementing one on one safety precautions is to ensure the safety of residents under our direct supervision. This involves preventing residents from (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	making contact with or causing harm to others, as well as ensuring that they are not permitted to self-harm .Procedure: A resident will be assigned to a specific nursing staff member who will remain in proximity to the patient at all times. Documentation on the special precautions and observation log will be done every 15 minutes . Resident #10 Review of an admission Record revealed Resident #10 was a male, with pertinent diagnoses which included a stroke with left sided hemiplegia (paralysis), anxiety, major depression, chronic pain, and a stage 3 sacral pressure ulcer. Review of a Minimum Data Set (MDS) assessment for Resident #10, with a reference date of 8/15/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated he was cognitively intact. In an interview on 9/8/25 at 2:56 PM, Resident #10 reported his wound treatments were supposed to be changed by staff twice a day but were .not always . completed as ordered. Review of the Treatment Administration Record (TAR) for Resident #10, for September 2025, revealed the ordered treatment Apply zinc oxide to sacrum BID (twice a day) and prn (as needed) if incontinent two times a day for prevention/protection . had 2 missed entries (no documentation) for the scheduled treatments on 9/4/25 at 8:00 PM and 9/6/25 at 8:00 PM. Review of the Treatment Administration Record (TAR) for Resident #10, for September 2025, revealed the ordered treatment Cleanse (sacrococcygeal) wound with normal saline. Cover wound bed with (MediHoney) and collagen, cover with foam border dressing. Change BID and prn as (Resident #10) allows for soiling or dislodgement every day and night shift for treatment . had 6 missed entries (no documentation) for the scheduled treatments on 9/1/25 (AM and PM), 9/2/25 (PM), 9/4/25 (AM and PM), and 9/7/25 (PM). Review of the Treatment Administration Record (TAR) for Resident #10, for September 2025, revealed the ordered treatment L (left) Scapula: Cleanse with NS (normal saline), pat dry gently and apply Optilock (dressing) or superabsorber (dressing). change BID and PRN as (Resident #10) allows when soiled or dislodged, encourage use of roho cushion (an air-filled cushion that provides pressure relief) every day and night shift for Wound care . had 6 missed entries (no documentation) for the scheduled treatments on 9/1/25 (AM and PM), 9/2/25 (PM), 9/4/25 (AM and PM), and 9/7/25 (PM). Review of the Treatment Administration Record (TAR) for Resident #10, for August 2025, revealed the ordered treatment Apply zinc oxide to sacrum BID and prn if incontinent two times a day for prevention/protection . had 7 missed entries (no documentation) for the scheduled treatments on 8/23/25 at 8:00 AM and 8:00 PM, 8/24/25 at 8:00 AM and 8:00 PM, 8/26/25 at 8:00 AM, 8/27/25 at 8:00 PM, and 8/29/25 at 8:00 PM. Review of the Treatment Administration Record (TAR) for Resident #10, for August 2025, revealed the ordered treatment Cleanse (sacrococcygeal) wound with normal saline. Cover wound bed with (MediHoney) and collagen, cover with foam border dressing. Change BID and prn as (Resident #10) allows for soiling or dislodgement every day and night shift for treatment . had 10 missed entries (no documentation) for the scheduled treatments on 8/14/25 (PM), 8/17/25 (AM), 8/19/25 (PM), 8/23/25 (AM and PM), 8/24/25 (AM and PM), 8/26/25 (AM), 8/27/25 (PM), and 8/29/25 (PM). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Treatment Administration Record (TAR) for Resident #10, for August 2025, revealed the ordered treatment L Scapula: Cleanse with NS, pat dry gently and apply Optilock (dressing) or superabsorber (dressing). change BID and PRN as (Resident #10) allows when soiled or dislodged, encourage use of roho cushion every day and night shift for Wound care . had 11 missed entries (no documentation) for the scheduled treatments on 8/14/25 (PM), 8/17/25 (AM), 8/19/25 (PM), 8/22/25 (AM), 8/23/25 (AM and PM), 8/24/25 (AM and PM), 8/26/25 (AM), 8/27/25 (PM), and 8/29/25 (PM). In an interview on 9/10/25 at 9:35 AM, Registered Nurse (RN) H reported Resident #10 was very particular with his care and who he would allow to complete wound treatments, often refusing ordered dressing changes. RN H reported his treatments were changed to twice a day in an attempt to increase compliance. RN H reported treatment refusals should be documented in the treatment record. In an interview on 9/10/25 at 1:07 PM, Unit Manager C reported Resident #10 often refused to allow nursing staff to complete his ordered wound treatments. Unit Manager C reported these refusals should be documented in the treatment record. Resident #69(R69) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R69's initial admission date to the facility was on 7/1/2020 with pertinent diagnoses including depression and anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 11 out of 15 which indicated R69 had moderate cognitive impairment (8-12 moderate cognitive impairment). During an interview on 9/8/2025 at 11:15 AM, R69 was lying in bed and was unable to communicate clearly whether he had been receiving showers. Review of R69's shower schedule revealed he receives showers 2 times a week on Wednesdays and Saturdays in the afternoon. Review of R69's shower/bath 30-day lookback revealed that R69 refused 2 showers/baths and had 2 shower/baths. From 8/23/2025 to 9/6/2025 there was no documentation regarding if a shower had been given or refused. During an interview on 9/9/2025 at 3:14 PM, Licensed Practical Nurse (LPN) J that Certified Nursing Assistants (CNAs) should let the nurse know when a shower refusal occurs and document it. During an interview on 9/9/2025 at 3:20 PM, CNA U stated that R69 tends to refuse showers and likes a bed bath better. CNA U said that CNAs should document refusals. During an interview on 9/9/2025 at 4:41 PM, Director of Nursing (DON) B stated that CNAs use the electronic medical record to document showers/bed baths and refusals. When discussing R69's showers/bed baths, DON B said that R69 prefers a bed bath and she knew he had one between 8/23/2025 to 9/6/2025 but it wasn't documented. Resident #54 (R54) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R54 admitted to the facility on [DATE] with pertinent diagnoses including paraplegia (loss of motor and sensory functions in both lower limbs) and insomnia (sleep disorder characterized by difficulty falling or (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staying asleep). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R54 was cognitively intact (13 to 15 cognitively intact). During an interview on 9/9/2025 at 8:06 AM, R54 revealed that the CNAs don't try hard enough to give shower/bed baths and if he isn't in his room they don't come back and give him a shower later that day. Review of R54's shower schedule revealed he receives showers 2 times a week on Mondays and Thursdays in the afternoon. Review of R54's shower/bath lookback since admission on [DATE] revealed that he had 1 refusal and 1 day where he wasn't available. There were 2 days with no documentation. During an interview on 9/9/2025 at 3:14 PM, LPN J stated that CNAs should let the nurse know when a shower refusal occurs and document it. During an interview on 9/9/2025 at 3:20 PM, CNA U stated that R54 refuses a shower/bed bath at times and said that CNAs should document refusals. During an interview on 9/9/2025 at 4:41 PM, Director of Nursing (DON) B stated that CNAs use the electronic medical record to document showers/bed baths and refusals. When discussing R54, DON B said that she knows that R54 had received bed baths since admission but it wasn't documented. Resident #9 (R9) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R9's initial admission to the facility was 7/30/2018 and currently has pertinent diagnoses including hemiplegia and hemiparesis following cerebrovascular accident affecting right dominant side (paralysis on right side of body that can affect the arms, legs and facial muscles), insomnia (sleep disorder characterized by difficulty falling or staying asleep) and aphasia (difficulty communicating) . Brief Interview for Mental Status (BIMS) reflected a score of 8 out of 15 which indicated R9 had moderate cognitive impairment (8-12 moderate cognitive impairment). During an interview on 9/8/2025 at 12:26 PM, Family Member RR stated that R9 had eloped (leaving the facility without staff knowledge) from the facility a few times and he had a wander guard on after the first incident which she was happy about. Review of R9's current physician orders revealed that there was no order for the wander guard. Review of R9's July physician orders revealed Confirm placement of wander guard on resident wheelchair every shift, d/c date (discharge date -end date) 7/7/2025. Review of R18's care plan revealed (R9) is at risk for exit seeking and/or wandering. interventions: check for wander guard placement and functioning. Wander guard is located under his wheelchair due to resident removing the wander guard upon several attempts to place on his person. Date initiated 9/19/2024. Review of the Risk for Elopement form dated 7/18/2025 revealed a score of 13 which indicated R9 was at risk for elopement due to his history of trying to leave the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/10/2025 at 7:54 AM, CNA O stated that she didn't think R9 had a wander guard on but they have been doing 15-minute checks on him. During an observation and interview on 9/10/2025 at 8:01 AM, LPN L showed this surveyor the wander guard underneath R9's wheelchair and stated that she checks the wander guard every shift she works and said there should be a physician order for it. When LPN L looked for the physician order in the chart, she couldn't find one and said that she knows to check for it even without the order since there used to be an order in R18's chart. LPN L said it probably wasn't put back in when he came back from the hospital in July. During an interview on 9/10/2025 at 10:21 AM, Social Services (SS) PP stated that R9 had a wander guard on due to his history of elopement and a physician order should be placed in the chart. During an interview on 9/10/2025 at 10:29 AM, DON B stated that R9 was doing better after signing onto Hospice in July and was coming out of his room more now. DON B said that wander guards are checked by nursing every shift and a physician order should be in the chart so the nursing staff know to look for it. DON B said that R9 went to the hospital in July and came back and was put on Hospice so the order must have been missed. DON B stated the physician order was just put in by LPN L that day and said, sorry it was missed. Resident #18 (R18) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R18's initial admission date to the facility was on 5/15/2020 with pertinent diagnoses including quadriplegia (loss of motor and sensory functions in all extremities), contracture of left and right elbow and contracture of left and right hand. Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 which indicated R18 was cognitively intact (13 to 15 cognitively intact). During an observation and interview on 9/8/2025 at 11:27 AM, R18 stated that he wants to have his splints put on after the CNAs stretch and do range of motion with him. He said they aren't putting the splints on. It was observed that both wrists were bent at a 90-degree angle. It was observed that R18 didn't have splints on during conversation.Further observations on 9/9/2025 and 9/10/2025, R18 did not have the splints on in the morning. Review of physician orders revealed (L) left elbow and (B) bilateral hand splints to be worn daily up to four hours as tolerated by resident in the morning for Restorative. Start date 3/18/2025. Review of R18's care plan revealed (R18) is at risk for a contracture development r/t (related to) spinal cord injury: C1 (fracture of the 1st cervical vertebrae) level of cervical spinal cord injury, contractures of bilateral hands and elbows. Date initiated 8/16/2022.interventions: L (left) elbow splints to be on for four hours daily as patient allows. Date initiated 9/18/2023. Review of R18's Kardex (CNAs follow it and it has resident specific information for all care areas on it) revealed Dressing/Splint Care: bilateral wrist, elbow splints to be on for 4 hours daily as patient allows. Review of August 2025 Treatment Administration Record (TAR) revealed (L) left elbow and (B) bilateral hand splints to be worn daily up to four hours as tolerated by resident in the morning for Restorative. Start date 3/18/2025. Hours 0600. There was no documentation for 4 days, 1 refusal and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the other days had check marks indicating he wore it. Review of September 2025 TAR revealed (L) left elbow and (B) bilateral hand splints to be worn daily up to four hours as tolerated by resident in the morning for Restorative. Start date 3/18/2025. Hours 0600. From 9/1/2025 to 9/10/2025, 9/3/2025 had no documentation, 1 day had a refusal and the other days had check marks indicating he wore it. On 9/10/2025 R18 was documented as wearing the splint by LPN L. During an interview on 9/9/2025 at 4:11 PM, LPN L stated that R18 refuses to have the splint put on since it's painful for him. During an interview on 9/10/2025 at 7:55 AM, CNA O said she hadn't put the splint on R18 before but she said he doesn't have it on very often. During another interview on 9/10/2025 at 7:59 AM, LPN L was asked why she already marked R18 as wearing the splint and she stated that the CNAs would try to put it on later. During an interview on 9/10/2025 at 8:10 AM, Director of Therapy (DOR) AAA stated that therapy worked with R18 and the CNAs to make sure the splint was put on properly. DOR AAA said that R18 refuses to wear the splints at times. During an interview on 9/10/2025 at 10:48 A, CNA AA stated that R18 refuses to wear splints quite often. During an interview on 9/10/2025 at 10:37 AM, DON B stated that R18 refuses to have the splint put on. When asked about the documentation for the splints, DON B said that a 2 should be indicated when R18 refuses and a check mark means that he wore it. When looking at the documentation for 9/10/2025, DON B questioned why LPN L marked that R18 wore the splints when he didn't. Resident #63 Review of an admission Record revealed Resident #63 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (left side weakness and paralysis following a stroke), contracture (shortening and hardening of muscles, tendons, or other tissues often leading to restricted joint mobility) left hand, and acquired absence of right toes (surgical removal of the toes). On 9/8/25 at 12:30 PM., Resident #63 was observed sitting in a wheelchair in her room, noted contracture of her left hand, no orthotic device was noted in her left hand. Orthosis/split (the shape of a carrot) device noted on top of the dresser in the corner of the room. Review of Order Summary for Resident #63 revealed (L) (left) Hand orthosis with Air Bladder donned with AM care, doffed with PM care as tolerated by pt. Skin to be monitored pre and post application for redness, skin break down and/or irritation. One time a day for place on resident with a start date of 8/7/2025. Review of Care Plan for Resident #63 revealed Need/Goal/Interventions: .is at risk for contracture development.will not develop any contractures.apply left hand air bladder as resident tolerates.initiated on 8/6/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/8/25 at 2:12 PM., Certified Nurse Assistant (CNA) Z reported Resident #63 had a carrot for her left hand but she refused to wear it. CNA Z reported Resident #63 had not worn her carrot in a long time. CNA Z stated no means no; I can't put her carrot in her hand if she doesn't want me to. CNA Z reported she has not applied Resident #63's carrot in weeks. CNA Z reported there was no way for her to document when Resident #63 refused. On 9/9/2025 at 9:11 AM., 11:38 AM., and 3:12 PM, Resident #63's left hand orthosis with air bladder (carrot) was not in place in her left hand. Orthosis/split (the shape of a carrot) device noted on top of the dresser in the corner of the room. Review of Treatment Administration Record (TAR) for Resident #63 for the months of August and September 2025 revealed (L) Hand orthosis with Air Bladder donned with AM care, doffed with PM care as tolerated by pt. with blank/missing documentation for 8/24/25, 9/1/2025 and 9/3/2025; all other days from 8/7/2025 to 9/9/2025 had documentation of Resident #63 having her left hand orthosis (carrot) in place each day. In an interview on 9/9/25 at 4:40 PM., Registered Nurse (RN) G reported Resident #63 had a carrot for her left hand but did not like to wear it. RN G reported the nurse was responsible for documenting the carrot being in Resident #63's left hand. RN G reported she could document Resident #63's refusal to wear her carrot as a progress note or in the TAR. RN G reported she documented Resident #63's refusal to wear her carrot this shift after this surveyor asked if she was wearing it. In an interview on 9/10/25 at 9:17 AM., Director of Nursing (DON) B reported her expectations when a resident refused something was that staff circled back to try again and all refusals should be documented by the nurse. DON B reported documentation was a problem she was aware of. DON B reviewed Resident #63's TAR for the month of September 2025 and reported the blanks/missing documentation indicated something wasn't done, and the check mark indicated it was done. DON B confirmed the documentation for Resident #63's left-hand orthosis indicted it was applied every day between 8/7/25 and 9/9/25 except for 8/24/25, 9/1/25, and 9/3/25 which had no documentation noted. In an interview and observation on 9/10/25 at 9:28 AM., Resident #63 was in bed and did not have her left-hand orthosis in place. DON B verbalized confirmation that Resident #63 did not have her left-hand orthosis in place and was unable to locate it in the room. Review of Resident #63's medical record revealed no additional noted documentation of refusals to wear left-hand orthosis.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living. Findings Include:On 9/8/25 at 2:11 PM, Observation of the central supply room found numerous items stored on the floor and underneath the storage racks. These items were personal hygiene products and care items for residents such as gauze and oxygen supplies. On 9/8/25 at 2:21 PM, Observation of the [NAME] Hall spa room found used gloves, a used razor, and a dozen used plastic razor guards, spread on the floor. Further review of the spa room found the underside of the shower bed with excess accumulation of what appeared to be, skin flakes, hair, bowel movement, and dirt debris. When asked about the shower bed Maintenance Director (MD) CCC, shook his head. On 9/8/25 at 2:40 PM, Observation of the Birch Hall spa room found eight washcloths laid out next to the sink. Further review found the shower call light cord was brown and black in sections with visible accumulation. Upon testing the call light in the shower area, it did not activate the call light or audible response in the hall when triggered. On 9/8/25 at 9:45 AM., the over the bed table in room [ROOM NUMBER] on the west hall was observed to be soiled with a spilled substance that was dry and appeared sticky. The floor was observed to be soiled with dirt, crumbs, brown spillage, and had visible trash present under and around the bed. On 9/8/25 at 9:56 AM, the floor in room [ROOM NUMBER] on the west hall was observed to be soiled with dirt, debris and had visible trash present on the floor. In an interview on 9/8/25 at 2:17 PM., Housekeeping Aide (HA) NN reported the facility was short a housekeeper and there was no one cleaning on the west hall. HA NN reported he was pulled to clean rooms after he finished cleaning the floors of the building. HA NN reported there were two full time and two part time housekeepers. HA NN reported the job he was hired for was floor technician. HA NN reported he would be able to clean about 3-4 rooms on the west hall before his shift ended. In an interview on 9/8/25 at 2:28 PM., HA NN reported there should be a housekeeper for each hall, but they do not have that kind of staff present. HA NN reported when they were short staffed the resident rooms only got the highlights of cleaning done. HA NN explained that got the highlights meant the housekeepers really only did the tables, and the trash unless there was visible soiled spot, then they would do that, but if the room looked clean, they don't worry about it. Only four rooms on the west hall were observed being cleaned on 9/8/2025. On 9/9/25 at 8:04 AM., the over the bed table in room [ROOM NUMBER] on the west hall was observed to be soiled with a spilled substance that was dry and appeared sticky. The floor was observed to be soiled with dirt, crumbs, spillage brown in color, and had visible trash present under and around the bed. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/9/25 at 8:15 AM, the floor in room [ROOM NUMBER] on the west hall was observed to be soiled with dirt, debris and had visible trash present on the floor. On 9/9/25 at 8:47 AM., there was observed light brown in color dried liquid spots on the floor beginning near the nurse's station and continuing ¾ of the way down the skilled hallway. In an interview on 9/9/25 at 10:53 AM., HA NN reported there were two housekeepers who called into work today and he was pulled to housekeeping to clean rooms instead of cleaning the floors. HA NN reported he was assigned all the rooms on the west hall and half of the rooms on the skilled hall to clean that shift. HA NN reported he would start with the rooms he did not get done yesterday and get as many done as he could. HA NN reported he was unsure if he would have time to do the floor of the building this shift. In an interview on 9/9/25 at 1:34 PM., Housekeeping Director (HD) QQ reported she was the interim housekeeping director, and she took over July 19, 2025. HD QQ reported she was the scheduler and was covering for payroll this week too. HD QQ reported every room should be cleaned daily and one or two rooms were scheduled for a deep clean daily. HD QQ reported a routine daily clean should include sweep and mop the floor, sanitize all the high touch surface areas, remove trash and clean the bathroom. HD QQ reported a deep clean included everything done daily and dusting, move the bed and clean the bed frame and mattress, the nightstand inside and out, and change the privacy curtain. HD QQ reported she rounded to check the deep cleaned rooms were completed. HD QQ reported she did not check the assigned deep cleaned rooms from yesterday, but she knew they did not get done. HD QQ reported the scheduled deep clean rooms were rescheduled for this upcoming weekend. HD QQ reported there were two call ins this morning, and there was no one to cover for them missing housekeepers other than HA NN. HD QQ confirmed that there was no housekeeper on the west hall yesterday and most of the rooms did not get cleaned as scheduled. In an interview on 9/9/25 at 1:57 PM., Nursing Home Administrator (NHA) A reported there was a problem with housekeeping and the facility had been without a director since March 2025. NHA A reported HD QQ had in the past taken to the floor to fill in and clean, but HD QQ did not do that yesterday. On 9/9/25 at 3:15 PM., NHA A reported he had instructed his management staff to assist with housekeeping in the facility. On 9/9/25 at 3:30 PM., HA NN reported he had cleaned 12 rooms today and had been told he was put on approved overtime to complete the cleaning of the remaining rooms. Review of Resident Council meeting notes dated 4/8/2025 revealed New business. room [ROOM NUMBER] is not getting cleaned. Review of Resident Council meeting notes dated 5/6/2025 revealed New business. Rooms are not being cleaned on a regular basis. Review of Resident Council meeting notes dated 6/3/2025 revealed .West Hall rooms not being cleaned regularly. Review of Resident Council meeting notes dated 8/5/2025 revealed Old business: Housekeeping.not mopping everytime or changing the trash everytime.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to 1). develop a person-centered care plan for 1 resident (Resident #7) and 2). implement person-centered care plan interventions for 1 resident (Resident #63) of 18 residents reviewed for person-centered care plan development and intervention implementation, resulting in Resident #7 not having a care plan related to hospice services in place and Resident #63 having increased risk for skin breakdown due to not wearing prevalon boot (prevalon pressure-relieving heel protector boot designed to minimize pressure, friction, and shear on the feet, heels, and ankles of non-ambulatory (non-walking) patients). Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 1: Resident Assessment Instrument (RAI), revealed .The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that.(1) the assessment accurately reflects the resident's status.(2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals.(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Resident #7: Review of an admission Record revealed Resident #7 was a male with pertinent diagnoses which included kidney disease, dementia, high blood pressure, prostate cancer, blocked and narrowed carotid artery (major arteries that run on either side of the neck supplying blood to the brain, face, and scalp), legal blindness and hearing loss. During an observation and interview on 09/08/2025 at 1:03 PM, Resident #7 was observed seated in his reclined Geri-chair across from the nurse's station along the wall to the dining room. CNA asked Resident #7 if he would like a shower and he replied he did. In an interview she indicated she was Hospice CNA BBB and had a trainee with her. Hospice CNA BBB reported she came to the facility a couple times a week to see Resident #7. Review of the medical record revealed there was no care plan for Resident #7 for Hospice services. In an interview on 09/10/2025 9:29 AM, MDS Coordinator E reviewed Resident #7's medical record and reported when an MDS was completed for hospice it would generate the care plan for hospice services. This had not yet been done. Resident #63 Review of an admission Record revealed Resident #63 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (left side weakness and paralysis following a stroke), contracture (shortening and hardening of muscles, tendons, or other tissues often leading to restricted joint mobility) left hand, and acquired absence of right toes (surgical removal of the toes). On 9/8/25 at 12:30 PM., Resident #63 was observed sitting in a Broda wheelchair (specialized wheelchair with a high back, tilt -in-space positioning and comfortable for long-term sitting) in her room with her bare skin of her feet/legs resting directly against the wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Order Summary for Resident #63 revealed Encourage (Resident #63) to wear pervalon boot to the left foot to off load pressure while in bed with a start date of 1/7/2024 and (L) (Left) Pressure Relief Ankle Foot Orthotics on with AM care and of with PM care, as patient allows with a start date of 8/27/2024. Review of Care Plan for Resident #63 revealed Need/Goal/Interventions: .is at risk for impaired skin integrity.will minimize risk in an effort to reduce likelihood of pressure injury development.left prevalon boot as tolerated initiated on 6/25/2024. In an interview on 9/8/25 at 2:12 PM., Certified Nurse Assistant (CNA) Z reported Resident #63 had a boot in the past for her left foot, but it was missing, and she did not wear it anymore. CNA Z reported that Resident #63 refused to wear her boot most of the time. CNA Z stated no means no; I can't force her to wear a boot she doesn't want to wear. CNA Z reported there was no way for her to document when a resident refused an assistive device, such as a prevalon boot. In an interview on 9/9/25 at 11:57 AM., Physical Therapist (PT) XX reported therapy recommended a soft boot for Resident #63 to protect her ankle from skin breakdown due to her continued crossing of her ankle over her leg. In an interview on 9/9/25 at 3:12 PM., CNA S reported she was not aware of any boot that Resident #63 should wear. During an observation on 9/9/25 at 3:21 PM., Resident #63 was in bed with her heel/feet/legs resting directly on the mattress. No prevalon boot was observed on Resident #63. The prevalon boot, light blue in color was observed in Resident #63's room closet, at the bottom, with other personal clothing items on top of it. During an observation on 9/10/2025 at 8:22 AM., Resident #63 was in bed with her heel/feet/legs resting directly on the mattress. No prevalon boot was observed on Resident #63. In an interview on 9/10/25 at 8:22 AM., CNA BB reported Resident #63 did not like to wear her boots and would refuse to wear them. In an interview on 9/10/25 at 9:17 AM., Director of Nursing (DON) B reported her expectations were that residents should wear any assistive devices ordered for them. DON B reported when a resident refused, her expectations were that staff circled back to try again and all refusals should be documented by the nurse. In an interview and observation on 9/10/25 at 9:28 AM., Resident #63 was in bed and not wearing a prevalon boot. DON B verbalized confirmation that Resident #63 did not have prevalon boot in place. Review of Resident #63's medical record revealed no noted documentation of refusals to wear prevalon boots.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an orthosis device (a device designed to prevent or prevent the worsening of contractures (the shortening and hardening of muscles, tendons, or other tissues often leading to restricted joint mobility) was used as ordered in 1 (Resident #63) of 2 residents reviewed for mobility resulting in the potential for the worsening of contracture of Resident #63's left hand.Findings include:Resident #63Review of an admission Record revealed Resident #63 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (left side weakness and paralysis following a stroke), contracture (shortening and hardening of muscles, tendons, or other tissues often leading to restricted joint mobility) left hand, and acquired absence of right toes (surgical removal of the toes). Review of a Minimum Data Set (MDS) assessment for Resident #63, with a reference date of 8/20/2025 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated Resident #63 was moderately cognitively impaired (BIMS score 8-12 indicates moderate cognitive impairment).Review of Order Summary for Resident #63 revealed (L) (left) Hand orthosis with Air Bladder donned with AM care, doffed with PM care as tolerated by pt. (patient) Skin to be monitored pre and post application for redness, skin break down and/or irritation. One time a day for place on resident with a start date of 8/7/2025.On 9/8/25 at 12:30 PM., Resident #63 was observed sitting in a wheelchair in her room, noted contracture of her left hand, no orthotic device was noted in her left hand. Orthosis/splint (the shape of a carrot) device noted on top of the dresser in the corner of the room.Review of Care Plan for Resident #63 revealed Need/Goal/Interventions: .is at risk for contracture development.will not develop any contractures.apply left hand air bladder as resident tolerates.initiated on 8/6/2025.In an interview on 9/8/25 at 2:12 PM., Certified Nurse Assistant (CNA) Z reported Resident #63 had a carrot for her left hand but she refused to wear it, and it had not been applied to Resident #63 left hand in weeks. CNA Z reported there was no way for her to document when Resident #63 refused.On 9/8/25 at 4:00 PM., Resident #63 was in bed, and no orthotic device was noted in her left hand.Review of the Treatment Administration Record (TAR) for Resident #63 for the months of August and September 2025 revealed (L) Hand orthosis with Air Bladder donned with AM care, doffed with PM care as tolerated by pt. with blank/missing documentation for 8/24/25, 9/1/2025 and 9/3/2025; all other days from 8/7/2025 to 9/9/2025 had documentation of Resident #63 having her left hand orthosis (carrot) in place each day.During observations on 9/9/2025 at 9:11 AM., 11:38 AM., and 3:12 PM, Resident #63's left hand orthosis with air bladder (carrot) was not in place in her left hand. Orthosis/split (the shape of a carrot) device noted on top of the dresser in the corner of the room.In an interview on 9/9/25 at 11:51 AM., Physical Therapy Assistant (PTA) VV reported Resident #63 had an air bladder orthosis device for her left hand. PTA VV reported nursing staff was responsible to apply Resident #63's orthosis.In an interview on 9/9/25 at 11:52 AM., Director of Rehab (DOR) WW reported Resident #63 was evaluated about a month ago for a split to try to lessen the contracture of her left hand. DOR WW reported the orthosis was referred to by the staff as a carrot due to the orthosis shape being like a carrot. DOR WW reported Resident #63's orthosis or carrot replaced a splint that was too painful for Resident #63 to tolerate.In an interview and observation on 9/9/25 at 3:12 PM., CNA S reported Resident #63 has a carrot for her left hand, but she was not wearing it. CNA S retrieved Resident #63's orthosis/splint (carrot) from atop the dresser in Resident #63's room to demonstrate visualization to this surveyor.In an interview on 9/9/25 at 4:40 PM., Registered Nurse (RN) G reported Resident #63 had a carrot for her left hand and the nurse was responsible for verifying and documenting the carrot being in place in Resident #63's left hand. RN G reported she was able to document if Resident #63 refused to wear the carrot. RN G reported Resident #63 refused (continued on next page)

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	09/10/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to wear her carrot today and she put in a progress note documenting Resident #63's refusal to wear her carrot. RN G reported she documented the refusal after this surveyor asked staff if she was wearing it. In an interview on 9/10/25 at 8:22 AM., CNA BB reported Resident #63 did not wear her carrot anymore.Further review of Resident #63's medical record revealed no additional noted documentation of refusals to wear left-hand orthosis/splint/carrot.In an interview on 9/10/25 at 9:17 AM., Director of Nursing (DON) B reported Resident #63 has a carrot for her left hand for her contracture and that she should be wearing it. DON B reported Resident #63 was a part of the restorative program; the program was new to the facility and part of the focus of the program was to prevent the worsening of contractures. DON B reported all the CNAs had been trained on restorative care with the training occurring in August 2024 and new hire staff being trained on restorative care during orientations. DON B reported the CNAs and nurses were responsible for the application of assistive devices such as Resident #63's carrot and nurses were responsible for charting regarding Residents wearing orthosis devices. DON B reported her expectations when a resident refused something was that staff circled back to try again and all refusals should be documented. DON B reported documentation was a problem she was aware of, and it was hard to get nurses to do their jobs. DON B reviewed Resident #63's TAR for the month of September 2025 and reported the blanks/missing documentation indicated something wasn't done, and the check mark indicated it was done. DON B confirmed the documentation for Resident #63's left-hand orthosis indicted it was applied every day between 8/7/25 and 9/9/25 except for 8/24/25, 9/1/25, and 9/3/25 which had no documentation noted. In an interview and observation on 9/10/25 at 9:28 AM., Resident #63 was in bed and did not have her carrot in her left hand. DON B verbalized confirmation that Resident #63 did not have her carrot in her left hand and DON B was unable to locate it in the room.Review of facility policy Restorative Nursing with a last revised date of 4/26/2024 revealed .A licensed nurse will help manage the restorative nursing process with assistance of nursing assistants trained in restorative care.3. Refer to specific restorative program procedures (s).Contracture Prevention and Management Program. 4. Determine resident willingness and ability to participate in a restorative program.5. If resident refuses to participate then care needs will be managed by nursing and other clinical staff.6. Document any refusals in the resident's medical record.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview, and record review, the facility failed to address/implement dietitian recommendations for nutritional supplements in 1 of 7 residents (Resident #10) reviewed for nutrition, resulting in the potential for impaired wound healing. Findings include:Resident #10 Review of an admission Record revealed Resident #10 was a male, with pertinent diagnoses which included a stroke with left sided hemiplegia (paralysis), anxiety, major depression, chronic pain, and a stage 3 sacral pressure ulcer. Review of a current Care Plan Report for Resident #10 revealed the need (Resident #10) is at risk for alteration in nutrition and fluid status r/t (related to) Stage 3 skin pressure area, depression, anxiety . revised 8/17/25, with interventions which included Request Vitamin C, zinc to promote healing initiated 7/24/25. Review of a Nutritional Re-Evaluation assessment for Resident #10, dated 2/25/25, revealed .Resident with varied intake between 50-100% at meals. Resident doesn't always eat meals served and has his own frozen, prepackaged meals/snacks .Stage 3 pressure injury is reported (to be) deteriorating .recommend (vitamin) C and zinc supplementation .Nutrition Interventions .500 mg (milligrams) vitamin C daily x 10 days .Zinc Sulfate 220 mg x 10 days . Review of a Nutritional Evaluation assessment for Resident #10, dated 5/26/25, revealed .Resident has stage 3 pressure injury on sacrum and scapula .Nutrition Intervention .vitamin C 500 mg, and zinc sulfate 220 mg x 10 days to support micronutrient needs in wound healing . Review of a Nutritional Re-Evaluation assessment for Resident #10, dated 7/23/25, revealed .Stage 3 pressure injury is reported (to be) deteriorating .The previous RD (Registered Dietitian) recommended (vitamin) C and zinc supplementation. However, I see no order. Will request again .Nutrition Interventions .(Vitamin) C, zinc to assist with wound healing . Review of a Nutritional Re-Evaluation assessment for Resident #10, dated 8/17/25, revealed .Stage 3 pressure injury is reported (to be) deteriorating .The previous RD recommended (vitamin) C and zinc supplementation. However, I see no order. Will request again .Nutrition Interventions .Request (Vitamin) C, zinc to assist with wound healing . Review of an Order Summary Report for Resident #10 revealed no physician orders for Vitamin C or Zinc supplementation between February 2025 and September 2025. In an interview on 9/10/25 at 11:13 AM, Registered Dietitian (RD) SS reported she completed an evaluation of Resident #10's nutritional status in August 2025. RD SS reported she requested Vitamin C and Zinc to promote wound healing, and stated, I don't know if that was implemented yet . RD SS reported when she makes nutritional recommendations, she sends the list of recommendations to Director of Nursing (DON) B who then implements the recommendations. RD SS reported she is not sure why the recommendations from July 2025 to add Vitamin C and Zinc were not implemented for Resident #10. In an interview on 9/10/25 at 1:59 PM, DON B reported that when the RD completes nutritional assessments, she typically sends an email with a list of the recommendations and then will also ask for the orders to be put into the computer when she is onsite. DON B reported RD SS is new to the facility, and past RD's entered their own orders based on the dietary/nutritional recommendations. DON B stated in regard to the nutritional assessments completed in February 2025, May 2025, July 2025, and August 2025 and the lack of physician orders in the medical record related to Vitamin C and Zinc supplementation, .He (Resident #10) did not get the supplements that she had recommended .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interviews, the facility failed to store trash and refuse containers covered and in a manner that maintains the area to prevent the harborage or feeding of pests.On 9/8/25 at 1:52 PM, Observation of the outside dumpsters, with Maintenance Director (MD) CCC, found the doors pushed open allowing for pests and precipitation to enter. An interview with MD CCC found that staff have a hard time tossing bags of trash into the dumpster unless the doors are opened. Further review of the dumpster area found excess trash, used gloves, and debris on the inside perimeter of the garbage area.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to track and offer the influenza and pneumococcal vaccines for 3 (Resident #9, #7, and #2) of 5 residents reviewed for immunizations, resulting in the failure to provide documentation of declination of immunizations and residents not being given the opportunity to receive or decline the influenza and/or pneumococcal vaccination. Findings include: According to the Centers for Disease Control and Prevention (CDC) PCV20 Vaccination for Adults 65 Years and Older dated 02/09/23, revealed, .Routine vaccination: Adults 65 years or older who have- Previously received both PCV13 and PPSV23, AND PPSV23 was received at age [AGE] years or older: Based on shared clinical decision-making, 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine dose . www.cdc.gov/vaccines/hcp/admin/downloads/job-aid-SCDM-PCV20-508.pdf Resident #9:Review of an admission Record revealed Resident #9 was a male with pertinent diagnoses which included paralysis on his right side, stroke, seizures, asthma, and heart failure. During an observation and interview on 09/10/2025 at 10:46 AM, Infection Preventionist (IFP) D reviewed Resident #9's medical record, it revealed he was not offered the PCV 20 or PCV 15 in 2024 after he turned 65 and there was no signed consent or declination in the medical record. IFP D reported he should have been offered the PCV 20 then. IFP D reported Medical Records (MR) OO was preparing for the influenza season vaccinations and was creating packets to send out to the resident's representative. Resident #7: Review of an admission Record revealed Resident #7 was a male with pertinent diagnoses which included kidney disease, dementia, high blood pressure, prostate cancer, blocked and narrowed carotid artery (major arteries that run on either side of the neck supplying blood to the brain, face, and scalp). During an observation and interview on 09/10/2025 at 10:50 AM, IFP D reviewed Resident #7's medical record which revealed under immunizations Resident #7 had refused the PCV20 vaccine. IFP D reviewed the medical record and was unable to discover a signed declination in the record for the refusal. Resident #2: Review of an admission Record revealed Resident #2 was a male with pertinent diagnoses which included heart failure, kidney disease, respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), COPD, dependence on oxygen, diabetes, and stroke. During an observation and interview on 09/10/25 at 10:54 AM, IFP D reported Resident #2 refused the influenza and pneumococcal immunizations as documented in the medical record. IFP D reviewed Resident #2's medical record and a consent was located in the medical record dated 3/29/24 for him to receive the influenza vaccination. Resident #2 had not been immunized with the influenza vaccine per the medical record documentation.