| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235487 | A. Building<br>B. Wing | 02/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Medilodge of West Bloomfield | 6950 Farmington Rd<br>West Bloomfield, MI 48322 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were treated with dignity and respect for two (R59 and R68) of three residents reviewed for dignity, including multiple anonymous residents that attended the confidential resident council interview. Findings include:R68<br><br>On 2/23/26 at 9:10 AM R68 was interviewed and queried about their stay at the facility. R68 reported, that the facility was okay but could be more initiative during the night shift. R68 reported that they could not get assistance on the night shift when they needed to use the restroom. R68 also reported that they only get changed once on the night shift and that is when the CNAs (Certified Nursing Assistant) first come around 11:00 PM/12:00 AM and they will not get changed again until 6:30 AM. R68 was then asked, how long did it take for someone to respond to the call light, R68, reported that someone will come in the room and ask what was needed and when they say bathroom, the CNA will turn light off and leave the room but not clean them up until the morning. R68 reported, that they us the restroom in their brief because during the nighttime, no one will assist them to the bathroom.<br><br>A record review revealed that R68 was admitted to the facility on [DATE] with an admission diagnosis of Difficulty in walking, Polyneuropathy and primary insomnia. R68 had a Brief interview for Mental status Score (BIMs) of 15 which indicated no cognitive impairment.<br><br>R59<br><br>On 2/23/25 at 10:03 AM, an interview was conducted with R59 and they were asked about their care at the facility. R59 reported that when they hit their call button to get assistance, it takes the CNA so long to respond that they forgot what they had called for. R59 also commented that it's hard for them to get their brief changed on the night shift and that they know the CNAs are short staffed.<br><br>A record review revealed that R59 was admitted to the facility on [DATE] with the admitted diagnosis of Urinary Tract infection, and Disorder of muscle and had a Brief interview for mental status score of 15, which indicated no cognitive impairment.<br><br>On 2/25/26 at 1:40 PM Family Member N requested to speak with someone from the state agency (SA) to report that the CNA's do not help R59 when they put their call light on at nighttime and the nurses do not give the nighttime medication until after 11:00 PM. Family Member N was then asked did they file a grievance with the facility and reported that the facility only gives grievance forms for missing items, not for nursing concerns. Family Member N also had a issue with the social worker at the facility, reported that the social worker never follows up or through on items or requests.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/25/26 at 2:30 PM, an interview with the facility staffing coordinator was conducted. The staffing coordinator was asked how the facility staffed and was there enough staff on each shift to ensure that residents needs were met. The staffing coordinator reported that they always overstaff the CNAs by one just to cover them if there is a call off, but each shift is filled with a lotted number, and the facility should never be short.<br><br>On 2/25/26 at 2:44 PM, an interview with the Regional Director of Operations (RDO)Q was conducted, she was told the concerns about residents not being able to be toileted in a timely manner. RDO Q reported that, the facility had been working on that and understood the issue with the timeliness of residents being toileted.<br><br>No additional information was provided by the exit of survey.<br><br>According to the facility's policy titled, Promoting/Maintaining Resident Dignity dated 10/26/2023:<br><br>.All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.During interactions with residents, staff must report, document and act upon information regarding resident preferences.Speak respectfully to residents; avoid discussions about residents that may be overheard.<br><br>Review of the past resident council minutes since September 2025 included the following dignity concerns reported by residents:<br><br>The meeting on 9/23/25 documented, cleaning staff were rude.<br><br>The meeting on 10/28/25 documented, Nurses and Aides are not being professional.<br><br>The meeting on 11/25/25 documented, Nurses and Aides are not being professional.Name tags are an issue.<br><br>The meeting on 12/30/25 documented, Nurse and aide's attitudes aren't professional.Name tags are an issue.<br><br>The meeting on 1/27/26 documented, Nurse and aide's attitudes aren't professional.Name tags are an issue. Foley never being emptied. Complains CENA (CNA) demanded her to put on a brief and lectured her about her incontinence.<br><br>On 2/24/26 at 1:30 PM, a resident council interview was conducted with eight residents that requested to remain anonymous. When asked if they felt staff treated them with dignity and respect, multiple residents reported ongoing concerns with lack of dignity. Resident responses included:<br><br>No!<br><br>Some of these aides and nurses don't have a heart for the people.<br><br>You can tell they don't actually care.<br><br>On 2/25/2026 at 10:45 AM, an interview was conducted with the Director of Nursing (DON) to review concerns from the resident council interview which included residents' expressions of feeling like<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | staff are not treating them with dignity and respect. The DON reported they had not been aware of dignity concerns and would have to address that. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2561059.Based on interview and record review, the facility failed to honor a full code advance directive for one (R146) of one reviewed, who wanted to receive all possible medical interventions in the event of a cardiac or respiratory arrest. R146 was found unresponsive, was not provided cardiopulmonary resuscitation (CPR) or other life saving measures as elected in their advance directives. Findings include:A review of a Facility Reported Incident (FRI) intake 2561059 reported the facility failed to ensure resident (R146) was free from neglect.Clinical record review revealed R146 was admitted on [DATE] and had diagnoses that included Parkinsons Disease (progressive neurological disorder) with dyskinesia (complication of Parkinson's Disease leading to involuntary movements of face, arms, legs, and torso) and encephalopathy (brain disease, damage, or malfunction). A Brief Interview of Mental Status (BIMS) reviewed from the Minimum Data Set (MDS) dated [DATE] scored 0/15 indicating R146 had severe cognitive impairment.Record review of the FRI revealed on Sunday [DATE], Licensed Practical Nurse (LPN) F went to care for R146 around 4:45 PM and observed R146 .unresponsive, eyes open-fixed, mouth open, checked his pulse, tried to get a blood pressure, no vitals. LPN F then had approached LPN G and told them R146 had passed. LPN F inquired the code status, and LPN F stated they were a Do Not Resuscitate (DNR). Around 4:56PM Registered Nurse (RN) B was called and pronounced the death of R146. LPN G reported that while LPN F was pulling the profile for R146 to identify the funeral home, it was documented R146 was in fact a full code.On [DATE] at 9:35 AM, an interview was conducted with RN B, who confirmed they were the RN in the facility that day. Per RN B they received a call that R146 had passed and needed to be pronounced. RN B said when they arrived, it was obvious R146 was deceased as they felt cooler (to touch) and were not breathing, I then pronounced (R146) and went back downstairs. Minutes later, (LPN G) called and said R146 was a full code at which time we ran our protocol, initiated full code measures and started CPR. Per RN B, nursing is responsible for knowing their residents code status and LPN F verbally confirmed R146 was a DNR.RN B further revealed after the miscommunication of code status, LPN F remarked why would we start CPR on someone if they are not breathing. RN B said .it was uncomfortably weird. that the nurse did not understand that is the reason you start CPR.On [DATE] at 10:25 AM, LPN F was phoned for an interview. Per LPN F it was a normal day. After they had returned from break, which was around afternoon shift change, they began rounding, went into R146's room which was the bed closest to the window and was observed unresponsive, and not breathing. LPN F stated they went for another nurse (LPN G) to help them. LPN F could not recall any details other than they were instructed to call the on-call supervisor. LPN F stated, (RN B) asked what I was doing on the phone, we need to run a code. Per LPN F they felt all alone, stated they did not know the rules there, was informed to just call the guardian. LPN F acknowledged they did not know the code status of R146, or any code status of all their assigned residents. LPN F did not know who was ultimately responsible for knowing resident code status and had no idea where it was documented. Per LPN F all the information regarding code status was not revealed until during the investigation of R146's death.Record review of the Facility Policy titled; Residents' Rights Regarding Treatment and Advance Directives dated [DATE]; documented: .Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the residents care.On [DATE] an interview with the Administrator confirmed due to the unexpected death of R146, determined that the facility's response to provide CPR and or other life saving measures was delayed. R146 was first found unresponsive on [DATE] at<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4:45 PM, at 5:31 PM, Emergency Medical Services (EMS) were dispatched at 5:31 PM and arrived at the facility at 5:36 PM. This was confirmed by telephone on [DATE] at 12:53 PM by Emergency Dispatch J.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:The Director of Nursing Services educated social services staff and licensed nurses regarding the documentation procedures for Advance Directives/code status. A chart audit of all residents was completed. Audits of new admissions and those residents on the MDS assessment schedule for consistent documentation of the resident's Advance Directive/code status throughout the electronic medical record. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>This citation pertains to intakes 2659810 and 2718805.Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, safe, and homelike environment, affecting all residents that access the ice machine and shower room. Findings include:On 02/23/2026 at 10:30 AM, the ice machine located in the upper-level pantry was observed to be leaking water onto the floor. The flooring was observed with a black, mold-like substance on the floor tiles. When queried at that time, Maintenance Supervisor S stated they were going to be getting a new ice machine but did not provide an explanation for why the mold-like substance on the floor had not been cleaned. In addition, in the upper-level pantry, the cupboard located under the sink was observed with visible water damage and a black, mold-like substance on the bottom shelf of the cupboard. Maintenance Supervisor S stated he had repaired a leak under that sink about a year ago but was not aware there was a new leak or water damage.<br><br>On 02/23/2026 at 3:30 PM in the upper-level shower room located next to the nurse's station, there was a bariatric shower chair observed with the vinyl covering of the seat torn away from the base of the seat, leaving exposed foam underneath, and a surface that was no longer smooth and easily cleanable. When queried at that time, Maintenance Supervisor S stated the seat would be replaced.<br><br>On 2/25/2026 at 10:51 AM, the Director of Nursing (DON) was asked to observe the C/D unit shower room. Upon entry into the shower room, there were two shower stalls. The shower stalls themselves were observed to have significantly pitched areas of the tiled flooring. The white vinyl shower curtain for the shower on the left was observed torn and heavily stained. The inside shower area was observed to have a heavy build-up of dark blackish colored debris along the wall and floor tiles. The tiled shower room walls were observed to have several chipped tiles, and the plastic corner coverings were observed to have missing caps at the top which exposed sharp metal and plastic edges. The DON reported they were not aware of that and would have the Administrator come down.<br><br>On 2/25/26 at 10:57 AM, an observation of the C/D shower room was conducted with the Administrator. During this time, the Administrator confirmed the same findings and further reported they were not sure how that had not already been identified prior to now. When asked about the missing end caps, soiled/ripped shower curtain and dirty shower tile, the Administrator reported they would have housekeeping come now.<br><br>According to the facility's policy titled, Safe and Homelike Environment dated 1/1/2022:<br><br>.Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.Report any unresolved environmental concerns to the Administrator. |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2621417. Based on interview and record review, the facility failed to ensure a safe discharge for one resident (R144) of two residents reviewed for discharge planning. Findings include: On 2/23/2026 a complaint submitted to the State Agency was reviewed which alleged the facility delayed in submitting the notification to the Michigan Department of Health and Human services that R144 had discharged from the facility and as a result, they could not access community level Medicaid services. On 2/24/26 the medical record for R144 was reviewed and revealed the following: R144 was initially admitted to the facility on [DATE] and discharged back to the community on 8/1/25. A review of R144's payor source at the time of their discharge was Medicaid-MI On 2/25/26 at approximately 10:55 a.m., during a conversation with the facility's Regional Business Office Manager I (RBOM I), RBOM I was queried regarding the process for switching a resident's Medicaid health insurance over from Nursing home level Medicaid to Community level Medicaid. RBOM I reported that the task is completed by the facility business office and it is usually done in electronic form but that due to the facility sale to another provider around that time, it would have had to be completed in paper or a call to the Department of Human Services (DHS). RBOM I was asked when the facility submitted the request to DHS to switch R144's Nursing home level Medicaid to community level Medicaid and RBOM I indicated that R144 discharged on 8/1 but a request for switching to community Medicaid was not made until 8/28/25. RBOM indicated it is usually done the day of discharge or the next day and at latest by end of the week. RBOM I was asked why there was an extensive delay in submitting the notification and they reported the previous business office manager was leaving at that time, and that was the reason for the delay in processing the notification to DHS. On 2/25/26 a facility document titled Social Services was reviewed and revealed the following: Policy: The facility, regardless of size, will provide medically-related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being The social worker, or social service designee, will pursue the provision of any identified need for medically-related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include: a. Assisting residents with financial and legal matters |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the facility nurses consistently followed the standards of practice for the administration and documentation of a controlled medication observed for the medication administration (R65) and failed to ensure that physicians orders were transcribed and carried out as ordered for one (R162) resident of three residents reviewed for closed records. Findings include:On [DATE] at 8:16 AM, LPN A was observed preparing the morning medications for R65. Included in the morning medications prepared was Ativan 0.5 mg (milligrams). LPN A was observed to have obtained one tablet of Ativan from the controlled medication locked drawer and added to the rest of R65 morning medications.<br><br>LPN A failed to verify R65's current Ativan count and failed to document the dose they removed on the controlled count sheet.<br><br>LPN A was observed to have prepared and administered three additional residents' morning medications, without signing out the Ativan dose administered to R65.<br><br>At 9:10 AM, LPN A was asked about their process of signing out the controlled medications they administered. LPN A replied they sign for their controlled medications after the administration of all the morning medications to the residents. LPN A was asked if that was the facility's protocol and LPN A responded some nurses sign out the medication after they remove the pill from the controlled count and some sign for it after they have administered all of the morning medications to their assigned residents.<br><br>A review of a facility policy titled Controlled Substance Administration & Accountability revised [DATE], documented in part . It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. a control count sheet which accompanies the medication will be placed in the controlled substance binder. The general standard of practice for documenting usage of . controlled medications is to. record each dose administered, subtract the dose administered from the previously recorded. and record the amount.<br><br>On [DATE] at 12:53 PM- the Director of Nursing (DON) was interviewed and was asked about the observation of LPN A to have administered the controlled medication without signing and subtracting for the controlled medication from the count. The DON stated they were aware of the observation with LPN A and had started education with the nurses.<br><br>No further explanation or documentation was provided by the end of the survey.<br><br>A record review revealed R162 was admitted to the facility on [DATE], expired at the facility on [DATE] with the admission diagnosis of Chronic diastolic heart failure and Stage 3 chronic kidney disease. R162 had a brief interview for mental status score of 00 which indicated severe cognitive impairment.<br><br>A further review of the recorded revealed a progress note completed on [DATE] read in part: Pt (patient) noted to be lethargic and difficult to arouse. Blood pressure observed to be low 102/72 P (pulse) 62 02 (oxygen saturation level) 97% RA (room air) R (respirations)18 temp (temperature) 97.6. patient respond to verbal stimuli and sternum rub but quickly falls back to sleep. Skin warm and dry.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | respirations even and unlabored. No acute distress noted at this time. Vitals obtained and repeated for accuracy. Patient repositioned for comfort and safety.MD (Medical Doctor) notified new lab orders STAT CBC w/ diff 9Complete Blood Count), CMP (Comprehensive Metabolic Panel), UA (urinalysis)/urine culture. New order IV (intravenous) hydrations 0.9 normal saline 70 cc/ hr (cubic centimeters per hour) for one liter. Q6 (every six hours) vitals x24 hours. will continue to monitor vital signs. call light within reach safety maintained.<br><br>Upon a further review of the record, it revealed that the orders for Intravenous (IV) Fluid 0.9 normal saline at 700 milliliters (CC) per hour for one liter was transcribed in the medical record for an incorrect start date which created a delay in medical treatment for R162. It was transcribed as . Sodium Chloride Solution 0.9 % Use 70 ml/hr intravenously everyday shift for 1 liter for 1 Day -Start Date-[DATE] 0700<br><br>On [DATE] at 10:21 AM, 11:45 AM and 1:15 PM an attempt to call the nurse who transcribed the order was contacted via phone with no answer.<br><br>On [DATE] at Approximately 2:00 PM an interview with the Regional Nurse Consultant(RNC) R was conducted. The RNC R was asked about the expectations for documenting and transcribing orders during a change in condition of a resident. They reported that it is expected that staff assess and monitor the residents, notify the provider and carry out any orders given. the RNC R also explained they should call the party responsible and if needed send the residents out to a higher level of care. RNC R was then asked why the order for IV hydration was set to start for the following day if it was ordered to be started on the same day. The RNC R reported that they were unable to speak on why it was not transcribed correctly. They were asked to see if they could get in contact with the nurse who created the order. The RNC R reported they would try as the nurse who transcribed the order no longer worked for the facility.<br><br>There was no additional information provided by the exit of the survey |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2696875 and 2718805.Based on interview, and record review, the facility failed ensure provision of medically-related social services regarding psychosocial well-being post abuse allegations, resident-to-resident incidents, and/or changes in mood/behavioral concerns for two (R35 and R49) of two residents reviewed for behavioral/emotional needs. Findings include:Review of complaints reported to the State Agency (SA) included concerns that R49 had been physically assaulted by R35, and the allegations that the facility's social worker was not assisting with necessary discharge paperwork to transfer to another facility or making time to visit with the resident.On 2/24/26 at 9:07 AM, the facility was requested to provide documentation of the facility's investigation regarding a resident-to-resident incident between R35 and R49. R35:Review of the clinical record revealed R35 was admitted into the facility on 7/18/25 and readmitted on [DATE] with diagnoses that included: vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. According to the most recent Minimum Data Set (MDS) assessment dated [DATE], R35 had severe cognitive impairment (Brief Interview for Mental Status/BIMS score was 5/15), and had verbal behavioral symptoms directed towards others which occurred one to three days during this look back period of seven days.Review of the documentation provided revealed the facility became aware of an allegation on 12/11/25 in which R49 had been physically and verbally assaulted by R35. The facility identified that R35 had moderate cognitive impairment according to the Minimum Data Set (MDS) assessment dated [DATE] and R49 had severe cognitive impairment according to the MDS assessment dated [DATE].The facility's assessment further revealed that the facility was unable to verify the allegation of abuse, but interventions were implemented to move R49 to a different room. The facility further identified that the facility social worker followed both residents and noted no effect to mood or routine was observed. The facility's documentation further identified that the social worker would follow up to monitor for changes in the resident's mood/behavior.Review of R35's progress notes revealed several entries of R35 swearing, resisting care, including medication. The most recent progress note on 2/2/26 at 10:40 PM read, Pt (patient) was verbally aggressive with roommate which led to pt getting physically violent with roommate. Writer observed pt attempting to hit roommate through the curtain and called the administrator to inform of the situation. Writer was advised to remove the pt until the morning.Review of the social service documentation revealed there were only two progress notes since December 2025 on 12/10/25 and 1/29/26 in which the family consented for continued medication (there were no details as to what medication they were consenting to).Review of the psych consultations included an entry on 1/7/26 at 2:35 PM by psych services read, .Psych Follow up flat affect mood lower motivation.(R35) has exhibited flat affect, low mood, decreased motivation, and lower body weight. She reports poor sleep and poor appetite.Today: Adjustment disorder remains on the active problem list in the long-term care setting. Plan: Provide ongoing supportive counseling/behavioral support through the facility and monitor for anxiety/depressive symptoms and behavioral changes.Further review of the social service documentation included an annual Social Service Progress Review completed by Social Service Director (SSD ‘C‘) dated 1/16/26 and locked on 1/19/26. This assessment was left incomplete for many pertinent sections and documented R35 was oriented, had no memory issue, was independent in daily decision-making skills, had a BIMS (Brief Interview for Mental Status) of 12 (moderate impairment) and the date of the most recent BIMS was 7/21/25. The section for Additional Cognitive/Mental Status comments was left blank.The section for Mood/Behavior/Emotional Status documented the most recent mood evaluation had been completed on 7/21/25 and the sections for Current Mood Status,<br><br>(continued on next page) |

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| | 235487 | A. Building<br>B. Wing | 02/25/2026 |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Current behavior status, Things that make you become anxious/agitated, Things that calm or soothe you, What are your comfort foods/drinks when anxious/stressed?, Describe and indicate any interventions being used to address mood or behavior problems/deficits were left blank.The section for Psychoactive Medication Review which prompted the assessor to List the psychoactive medication name, related diagnosis and last GDR (Gradual Dose Reduction) or contraindication was left blank.Review of R35's social service documentation revealed there was no follow up following the resident-to-resident incident in December or February. R49:Review of the clinical record revealed R49 was admitted into the facility on 9/24/25 and discharged to hospital on 2/22/26 with return expected. Diagnoses included: major depressive disorder recurrent, generalized anxiety disorder, unspecified dementia, unspecified severity, with other behavioral disturbance, and adjustment disorder.According to the MDS assessment dated [DATE], R49 had severe cognitive impairment (scored 3/15 on BIMS exam) and had no mood or behavior concerns.Review of the social service assessments revealed there was only one assessment completed with a date of 9/29/25 and a lock date of 10/1/25. There was no quarterly assessment available for review. This assessment also revealed multiple incomplete sections which included: .Behavior, Medical, and Psychiatric History .Document major health occurrences and the social, behavioral, emotional impact .(left blank) .admitted on a psychoactive medication(s) .a. Yes .PARoxetine .Admitting behaviors or mood disorders (left blank) .History of other behaviors or mood disorders (left blank) .Things that make you become anxious/agitated (left blank) .Things that calm or soothe you( left blank) .What are your comfort foods/drinks when anxious/stressed? (left blank) .Any foods/drinks you have every day/consistently? (left blank) .How do you handle conflict? (left blank) .BIMS score 3 .Further review of the clinical record revealed:An entry on 1/7/26 at 8:04 PM read, Pts family informed writer that roommate was being verbally aggressive with pt. Pts family wanted roommate to be removed from the room so that the situation would not escalate. Writer temporarily moved pts roommate to room [redacted] per administrator's orders. There was no documented follow-up by SSD 'C' following this incident.An entry on 12/19/25 at 2:31 PM by SSD ‘C‘ revealed no documentation they had assessed or evaluated the resident's psychosocial well-being following the alleged incident on 12/11/25 with R35. This note only identified the family was contacted regarding psychotropic medication consent.An entry on 12/10/25 at 2:00 PM by psych read, .The patient has been experiencing ongoing depression and anxiety related to her loss of physical abilities, particularly her inability to walk, and expresses distress about her loss of autonomy and total reliance on facility staff to meet her needs.Staff has reported that she becomes agitated and frustrated at times when her needs are not immediately addressed. Behavioral notes have documented episodes of yelling/screaming, verbal aggression, threatening behavior, and refusing care. She has exhibited helpless and hopeless ideation but has consistently denied any intent to harm herself.Review of the social service documentation revealed there was no follow up following the resident-to-resident incident in December or February, or the more recent progress note entries identified above.On 2/24/26 at 8:33 AM, an interview was conducted with SSD ‘C‘. When asked to explain how they assessed residents for their psychosocial needs, including those with behavioral needs, assessment, and monitoring, SSD ‘C‘ reported they would have to get back with this surveyor. When asked how the direct care staff knew to monitor for behavioral changes specific to each resident, SSD ‘C‘ reported they were not sure what the direct care staff could see. When asked if they discussed anything at interdisciplinary meetings, SSD ‘C‘ reported they did daily stand ups and words that staff entered would get flagged for discussion. When asked if they utilized a behavioral management program to discuss and review interventions for residents with behavioral needs, SSD ‘C‘ reported they did not and referred to psych services. When asked where their notes would be<br><br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | documented in the clinical record, they reported those would be under progress notes. They were unable to offer any further explanation as to the lack of complete and/or accurate assessments.On 2/25/26 at 1:05 PM, an interview was conducted with the Administrator. At that time, the Administrator was informed of the concerns regarding lack of complete and accurate social service assessments, or follow-up following the resident-to-resident incident with R35 and R49. The Administrator reported SSD ‘C‘ was expected to follow-up as a general process following incidents such as those and further reported if there was a barrier to why SSD ‘C‘ was not able to do that, that was not expressed. The Administrator further reported they had several previous discussions with SSD 'C' about similar issues and they would have to follow-up.According to the facility's policy titled, Social Services dated 10/30/23: .The social worker, or social service designee, will complete an initial and quarterly assessment of each resident, identifying any need for medically-related social services of the resident. Any need for medically-related social services will be documented in the medical record.Services to meet the resident's needs may include.Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident.Meeting the needs of residents who are grieving from losses and coping with stressful events.The resident's plan of care will reflect any ongoing medically-related social service needs, and how these needs are being addressed.will monitor the resident's progress in improving physical, mental, and psychosocial functioning. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2621426Based on observation, interview and record review the facility failed to ensure accurate and timely medication administration was provided to a resident who required seizure medication for one (R43) out of seven residents reviewed for medication administration. Findings include:A complaint was filed with the State Agency (SA) that alleged on 9/15/25, Nurse N falsified they provided R43 with their needed seizure medication (Valproic Acid) resulting in the resident sustaining two seizures during the night. The complainant further alleged that Nurse N often provides medication late or not at all.On 2/23/26 at approximately 11:43 AM, R43 was observed lying in bed. The resident was receiving tube feeding and oxygen. R43 could not answer any question asked.A review of R43's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: other seizures, neuromuscular dysfunction of bladder and contractures of muscle, multiple sites. The resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 99 (severely cognitively impaired).Continued review of R43's medical record revealed the following:R43 had an order for the medication Valproic Acid Oral Solution 250 MG/5ML (milligrams/milliliters).Give 15 ml via PEG-Tube two times a day related to Other Seizures. scheduled at 7:30 AM and 9:00 PMA review of R43's Medication Administration Record (MAR) noted that on 9/15/25 the was administered by Nurse N and 9:00 PM by Nurse P. The facility was asked to provide the actual time(s) R43 received their medication on 9/15/25. The facility provided the Medication Admin Audit Report for 9/15/25. A review of the Audit revealed that the medication Valproic Acid had a Schedule Date/Time of 9/15/2025 7:30 AM, but the actual Administration Time and Doc'd (documented) time was 12:44 (PM) by Nurse N. An attempt to locate the Administration of the Valproic Acid at 9:00 PM as noted in the order could not be located on the Medication Admin Audit Report.9/16/25 (4:56 AM) Nurses' Note: at 4:23 pt (patient) was observed having an active seizure, ending at 4:22 stated second seizure at 0423 that lasted until 0425 pt was turned on left side with suction available.physician contacted.On 2/25/26 at approximately 12:00 PM, an interview and record review were conducted with the Director of Nursing (DON). The DON was asked about the facility's policy/protocol for medication administration. The DON reported that medications should be administered as ordered allowing only one hour prior to the order or one hour after for administration. The DON noted that the facility did not have a liberal administration protocol. The DON confirmed that the order for Valproic Acid that was scheduled to be Administered at 7:30 AM and not administered until 12:44 PM, was significantly delayed. The DON was asked to further review the Audit to determine if the 9:00 PM Valproic was administered to the R43. On 2/25/26 at approximately 1:04 PM, the DON reported that after reviewing the Audit it was determined that the resident never received the 9:00 PM order for Valproic acid.The facility policy titled, Medication Errors (1/24/2024) was reviewed and read as follows:.Policy: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors.The facility shall ensure medications will be administered as follows: According to physician's orders.in accordance with accepted standards and principles which apply to professionals providing services.The facility will consider factors indicating errors in medication administration, including.time of administration;.medication omission. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>This citation pertains to Intake 2659810.Based on observation, interview, and record reviews the facility failed to ensure infection control standards and practices were consistently implemented by the facility staff and failed to implement an effective infection control surveillance program. Findings include:Medication Observation<br><br>On 2/24/26 at 9:01 AM, Licensed Practical Nurse LPN A was observed to have administered medications to four Resident's (R's) that included R's- 9 & 65 without performing hand hygiene before each medication administration for each resident.<br><br>A review of the facility policy titled Medication Administration reviewed 1/17/23, documented in part . Medications are administered by licensed nurses. Wash hands prior to administering medication per facility protocol and product. Administer medication as ordered. Observe resident consumption of medication. Wash hands using facility protocol.<br><br>On 2/25/26 at approximately 12:55 PM, the Director of Nursing (DON) was interviewed and asked the facility's protocol regarding hand hygiene with medication administration and acknowledged that nurses should be following the facilities protocol and performing hand hygiene before and after each medication administration for each resident.<br><br>On 2/25/26 at 12:30 PM, The Facility Infection Control Registered Nurse (RN) B was interviewed to review the facility's Infection Control and Surveillance program. When asked if the facility had any recent outbreaks, RN B acknowledged in October 2025 there was a COVID outbreak that affected 13 residents and six staff members.<br><br>RN B retrieved the facility Respiratory Surveillance Line List dated 10/01/25 and verified the names on the list were all those who had tested positive for COVID. The document did not document COVID but was a verbal confirmation by RN B<br><br>Record Review of the document revealed demographics such as names, age, gender, resident/staff resident stay status (short/long) resident room/bed.<br><br>Diagnostics for all names listed documented was NP (Nasopharyngeal Swab)<br><br>Date of collection was blank.<br><br>Type of test ordered was documented 4 (4: Other Specify) and not specified.<br><br>Symptom onset date for some were N/A (not applicable) or blank.<br><br>Columns for documenting signs and symptoms were all blank.<br><br>Pathogen detected was documented 7 (7: Other Specify) with no documentation of what other was and the outbreak symptom resolution date was blank for all names.<br><br>Infection Control RN B was asked if this was the entire surveillance list and they confirmed it was. When questioned if this was an outbreak, why was the surveillance lacking many key components, RN B was not sure, and replied, it was just blank.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | When asked to review October 2025 facility map of infections, the map did not indicate what residents had COVID for the month.<br><br>Record review of the facility policy titled: Infection Prevention and Control Program dated 12/2023 documented:<br><br>.Surveillance: A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, volunteers, visitors.The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement a program that monitors antibiotic use.<br><br>Based on interview, and record review, the facility failed to monitor appropriate use of antibiotics for one (R14) of three reviewed for antibiotic stewardship program to ensure all resident's prescribed antibiotics are monitored for the right indication, dose, and duration. Findings include:On 2/25/26 at 12:30 PM, the Facility Infection Control Registered Nurse (RN) B was interviewed to review the facility's antibiotic stewardship program.Clinical record review revealed on 10/14/25, R14 was observed vomiting yellow green emesis was sent to the hospital and returned the same day with antibiotic orders for a Urinary Tract Infection (UTI), RN B replied they were diagnosed while they were at the hospital and sent back with the orders.The facility Infection Report Form completed by Infection Control RN B documented R14 onset date 10/13/25, suspected infection Urinary Tract infection classified as Healthcare Associated (HAI). Keflex (an antibiotic medication) 500 milligram (mg) given every six hours was to start on 10/14/25 and stop on 10/18/25. A second antibiotic, Macrobid 100 mg given twice a day was to start on 10/17/25 and stop on 10/22/25.The attached McGeer Criteria for Infection Surveillance Checklist documented R14's name, medical record, unit and date of infection documented 10/14/25. The criteria were not completed but RN B provided a spreadsheet indicating R14 did not meet McGeer's criteria.When questioned if R14 did not meet criteria, then why did they continue to receive antibiotics, RN B said they continued all orders because the hospital said they had a UTI and Doctor M wanted it continued. When asked where this conversation was documented, RN B replied there was no documentation. When questioned if R14 was reassessed after antibiotics were ordered RN B replied that do not personally reassess the residents and was not sure if the facility physicians assessed their relevance either.Review of the facility policy titled Antibiotic Stewardship Program dated documented.Monitor response to antibiotics.to determine if the antibiotic is still indicated or adjustments should be made.Antibiotic orders obtained from consulting, specialty, or emergency provider shall be reviewed for appropriateness. |