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

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 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 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. 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. 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. 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. 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 Record Review of the document revealed demographics such as names, age, gender, resident/staff resident stay status (short/long) resident room/bed. Diagnostics for all names listed documented was NP (Nasopharyngeal Swab) Date of collection was blank. Type of test ordered was documented 4 (4: Other Specify) and not specified. Symptom onset date for some were N/A (not applicable) or blank. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Columns for documenting signs and symptoms were all blank. 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. 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. When asked to review October 2025 facility map of infections, the map did not indicate what residents had COVID for the month. Record review of the facility policy titled: Infection Prevention and Control Program dated 12/2023 documented: .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 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. **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 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. 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. R59 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. 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. 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. 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. 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents being toileted. No additional information was provided by the exit of survey. According to the facility's policy titled, Promoting/Maintaining Resident Dignity dated 10/26/2023: .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. Review of the past resident council minutes since September 2025 included the following dignity concerns reported by residents: The meeting on 9/23/25 documented, cleaning staff were rude. The meeting on 10/28/25 documented, Nurses and Aides are not being professional. The meeting on 11/25/25 documented, Nurses and Aides are not being professional.Name tags are an issue. The meeting on 12/30/25 documented, Nurse and aide's attitudes aren't professional.Name tags are an issue. 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. 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: No! Some of these aides and nurses don't have a heart for the people. You can tell they don't actually care. 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 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 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. 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. 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. 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. 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. According to the facility's policy titled, Safe and Homelike Environment dated 1/1/2022: .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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure an environment free from accident hazards related to resident smoking and storage of smoking paraphernalia for three (R3, R5 and R88) of five residents reviewed for accidents and multiple residents that attended the confidential resident council interview. Findings include:According to the facility's Acknowledgment of Facility Smoking Policy, .It is the policy of this facility to establish and maintain safe resident smoking practices. This policy also includes electronic cigarettes. This policy is used to educate residents and representatives. The Facility permits smoking in designated areas only outside of the building(s) under the following conditions .Smoking times (cigarettes, lighters, etc.) will be kept secured in a designated are with limited staff access. Resident shall not keep any smoking materials in resident rooms .A list of smoking times shall be given to residents with smoking privileges. Residents will also be allowed to smoke in the designated smoking areas during off-scheduled times with a family member or visitor who is able to appropriately supervise the resident for smoking safety .Only Facility provided ashtrays shall be used .The Attending Physician and the Director of Nursing Services (DNS) shall have the authority to make the determination as to what restrictions, if any, will need to be placed on the resident's smoking privileges .Any resident with smoking privileges shall not be permitted to smoke without the direct supervision of a responsible staff member, family member, visitor or volunteer worker and direct supervision must be provided throughout the entire smoking period . Review of the facility's documentation provided for Resident Council included a concern from 9/23/25 regarding residents smoking outside under the canopy. On 2/24/26 at 1:30 PM, a resident council group interview as conducted with eight residents. All residents in attendance requested to remain anonymous. When asked about the facility's smoking practices for residents, several residents expressed concerns with other residents seen with smoking materials such as vapes and smoking near the entrance. One resident stated there were times they went outside in the summer and didn't feel like they could because there are residents smoking out there. One resident verbalized that they smoke but were aware they had to go to the sidewalk at the edge of the property. On 2/24/26 at 10:05 AM, an interview was conducted with the Administrator. When asked if they could explain more about what the concern was related to smoking as identified in the resident council, the Administrator reported there was a concern about a resident vaping in the facility. The Administrator reported R3 was observed pulling out vape materials and that their family was bringing those items in and were asked to stop bringing them in. The Administrator reported they thought it wasn't an issue lately and that was more in the past fall time. When asked to explain the facility's process for residents that smoked, including vapes, the Administrator reported they were technically a non-smoking facility, but residents were able to sign out on an LOA (leave of absence). The Administrator acknowledged there were residents that vaped and they were able to sign out on LOA. They further reported they had many discussions as an interdisciplinary team about changing the facility's smoking practices and didn't feel it was safe for residents to necessarily be on the sidewalk by the main road given the multiple elevation changes. The Administrator further acknowledged that although there was an acknowledgment of smoking policy, they were technically a non-smoking facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked if residents were not their own responsible party, how were they able to sign themselves out on LOA, the Administrator reported they had QA'd (Quality Assurance) potential policy for dedicated times and also have issue with staff not wanting to be exposed to smoke and also discussion with the Ombudsman who said we can't take their smoking materials. The Administrator was asked given the facility staff were aware of residents that smoked, what processes were put in place to ensure they were assessed to be able to safely smoke unsupervised, or if they needed supervision and items such as a smoking apron, cigarette holder, etc., as well as where the smoking materials were stored. The Administrator reported they were not able to offer any further explanation. The Administrator was informed of the observations during survey of a resident observed with smoking paraphernalia and visible smoke cloud inside, and an unknown resident that requested a surveyor to pick up a cigarette butt from the ground outside the main entrance/awning and insisted that was their cigarette they intended to smoke and they reported they were not aware. R3: Review of R3's clinical record revealed there were no smoking assessments to identify if the resident had been assessed for safe smoking, handling of smoking materials and whether any adaptive needs were required. Review of the care plans included one initiated on 7/25/25 that read, Resident chooses to smoke. The one goal read: Resident will smoke safely at the designated area(s) at scheduled times through the next review. There were no current designated areas/scheduled times per Administrator. Interventions included: Adaptive equipment for safe smoking (SPECIFY). This was noted as initiated on 7/25/25, revised on 8/21/25, but was left incomplete and didn't identify any specific adaptive equipment. Observe the resident's safety during smoking. This was initiated on 7/25/25. Further review of the clinical record revealed R3 was admitted into the facility on 7/16/25 from another nursing home with diagnoses that included: acute diastolic (congestive) heart failure, chronic obstructive pulmonary disease, nicotine dependence, morbid obesity due to excess calories, adjustment disorder with mixed disturbance of emotions and conduct, borderline personality disorder, bipolar disorder in partial remission most recent episode mixed, other specified disorders of muscle, other specified depressive episodes, bipolar disorder, current episode mixed, severe, with psychotic features, mood disorder, conversion disorder with seizures or convulsions, and obstructive sleep apnea. On 2/25/26 at 10:30 AM, an interview was conducted with the Director of Nursing (DON). When asked who usually implements the care plans for residents that were identified as a smoker, the DON reported usually MDS Nurses do, the DON or Unit Managers. When asked if there were any assessments completed to determine safe smoking practices, the DON reported there was currently no option in the electronic medical record to do safe smoking. When asked about R3's history of vape use, the DON reported we educate and confiscate the ones she has, and family will bring in later. R88 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/23/26 at 11:32 AM, R88 was observed in their room throwing a purple vape pen in their purse. A dissipating smoke cloud was observed. On 2/25/26 at 9:57 AM, R88 was observed lying in bed. A black vape pen was observed on their bed. When asked if they used the vape pen in their room, R88 replied in part . I may do it from time to time. R88 explained that sometimes they would go out of the facility to use the vape pen as well. A review of the medical record revealed R88 was admitted to the facility on [DATE] with the primary diagnosis of malignant neoplasm of the lung (lung cancer). A review of the progress notes revealed the following: A Nursing note dated 1/6/26 at 3:25 AM, documented in part . Resident was caught in her bathroom smoking cigarettes. writer asked resident to give her the cigarettes and lighter. resident stated here go the cigarettes I don't know where the lighter is. resident handed the cigars to nurse. nurse locked cigars in cart. Administrator and DON, MD (Medical Doctor) notified. no new orders . A Nursing note dated 10/22/25 at 7:56 PM, documented in part . At approximately 2100 (9 PM), patient was found smoking in her room by the caregiver. The caregiver immediately reported the incident to writer. Upon assessment, patient was alert and oriented ×3, calm, and in no apparent distress. No burns, shortness of breath, or other injuries noted. The cigarette was extinguished and disposed of safely. Patient was reminded of the facility's no-smoking policy and educated on fire safety and health risks of indoor smoking. Patient verbalized understanding. Incident reported. Will continue to monitor and reinforce safety protocols . A review of the assessments revealed no smoking assessment was completed for R88. A review of the care plans revealed no care plan and/or interventions implemented for the usage of the vape pen. On 2/25/26 at approximately 12:57 PM, the Director of Nursing (DON) was interviewed and asked about the observations noted in the residents' chart and discussed the observations of the survey of R88. The DON acknowledged that the facility was a non-smoking facility, however recently found out that they had a policy for residents that smoke. The DON acknowledged the concern and stated they would follow up with their team. No further explanation was provided by the end of the survey. R5: On 2/25/26 at 9:30 AM, R5 was interviewed and openly acknowledged they are a smoker and acknowledged the facility knows their wishes do not want to quit. When asked where they get their cigarettes and lighter, R5 replied I keep them on my person R5 said there was never a smoking assessment performed for them and if there was, it was maybe when they were first admitted but could not confirm. Review of R5's care plan documented: Resident chooses to smoke. Date Initiated: 07/31/2025 Revision on: 07/31/2025 Inform resident or /family/responsible regarding the center's smoking policy, designated smoking areas, and storage of smoking materials. Date Initiated: 07/31/2025 Offer resident a smoking cessation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure expired medications were discarded from one medication storage room of two medication storage rooms reviewed. Findings include:On 2/25/26 at 12:10 PM, an observation and review of the medication storage room located on the ground floor was conducted with Registered Nurse (RN) E. Observed in the medication storage cabinet were the following expired medications with the date of 01/2026 - liquid pain relief acetaminophen 160 mg (milligram)/5 ml (milliliters), glucosamine and chondroitin (two bottles) and Vitamin B-6 (two bottles). RN E verified the expiration date and stated that all of the expired bottles should have been removed from the storage unit. RN E removed the expired bottles and stated they would ensure they were discarded per the protocol.On 2/25/26 at 12:53 PM, the Director of Nursing (DON) was interviewed and asked about the observation of the expired medication bottles in the facility's storage room. The DON stated central supply staff are supposed to maintain the medications in all of the facilities storage rooms. The DON stated they were made aware of the expired medications and had since removed them from the medication storage room.A review of the facility's medication Storage policy revised 1/30/24, documented in part . It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations.No further explanation or documentation was provided by the end of the survey.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 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.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and record review, the facility failed to ensure an emergency pull cord to was available within the immediate shower area (accessible if lying on the floor) for two shower stalls, affecting all residents that utilize the C/D shower room. Findings include: On 2/24/26 at 1:30 PM, a confidential resident council interview was conducted with eight residents. When asked about whether there were any concerns regarding the facility's physical environment, several residents reported concerns. Responses included: I get my own showers and Nursing staff tell me they have to stay in, but some don't stay in. I'm solo when they step out of the shower room. The pull cord is across the room, what happens if I fall in the shower? There is no pull cord in the shower.On 2/25/2026 at 10:51 AM, the Director of Nursing (DON) was asked to observe the C/D unit shower room. Upon entering the shower room, there were two shower stalls and each of them did not have an emergency pull-cord in the vicinity. The closest emergency pull-cord was on the wall outside of the shower stalls approximately eight feet away. The shower stalls themselves were observed to have significantly pitched areas of the tiled flooring. The DON reported they were not aware of that and would have the Administrator come down.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.Review of the facility's policy titled, Call Lights: Accessibility and Timely Response dated 12/28/2023 did not address the proximity of the call-light in shower areas, or if a resident was lying on the floor.

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F 0578 Level of Harm - Minimal harm or potential for actual harm 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. **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 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 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review the facility failed to ensure the appropriate Notice of Medicare Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) were provided and completed for three (R10, R127 and R164) of three residents reviewed for beneficiary notification, resulting in the residents and/or representatives to be uninformed of the potential private pay charges for continued services at the facility, and the inability to file an appeal. Findings include:On 2/23/26 at 1:20 PM, during an interview with R10's family, they expressed concerns with the facility's documentation for Medicare A coverage.On 2/25/26 at 2:30 PM, the Administrator was requested via email to complete and provide the applicable documentation in accordance with the instructions provided on the SNF (Skilled Nursing Facility) Beneficiary Worksheet for each of the following three residents R10, R127 and R164. These residents were identified on the documentation provided by the facility (Residents for the past six months that had Medicare A benefits and were either discharged home or remained in the facility). The instructions on the SNF Beneficiary Worksheets identified to NOT include those residents that exhausted their Medicare A benefits.Review of the documentation provided by the facility revealed only the SNF Beneficiary Notification Review worksheets for R10, R127 and R164. There was no additional documentation as instructed on the worksheet to provide the Notice of Medicare Non-Coverage (NOMNC) and/or if a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) documents for any of the residents.On 2/25/26 at 4:00 PM, the Administrator was not available and the Regional Director of Operations (RDO ?Q?) offered to assist. They were informed of the concern with the initial request and lack of documentation provided and they stated they would follow-up.Further review of the available documentation provided revealed:The SNF Beneficiary Worksheet for R127 documented their Medicare A benefits started on 9/1/25, their last covered day was 11/19/25 and they were not issued a SNFABN or NOMNC because they exhausted benefit days.The SNF Beneficiary Worksheet for R10 documented their Medicare A benefits started on 12/29/25, their last covered day was 2/16/25 and they were not issued a SNFABN or NOMNC because they exhausted benefit days. R10 was also identified on the facility list provided as being cut from Medicare A benefits on 10/8/25 and remained in the facility. There was no other documentation provided for this benefit period.The SNF Beneficiary Worksheet for R164 documented their Medicare A benefits started on 7/15/25, their last covered day was 9/5/25 and they were issued a NOMNC. However, the NOMNC was not provided for review.On 2/25/26 at 4:25 PM, the Administrator was informed of the concerns with lack of documentation provided for review per the instructions on the worksheets. At that time, the Administrator provided a NOMNC for R10 that documented their Medicare A benefits would end on 10/7/26 and a note from the Social Service Director (SSD ?C') on the bottom of the form read, Patient refused to sign. Left copy at bed side. 10-3-25. There was no documentation provided that a SNFABN was provided since the resident remained in the facility after 10/7/26 to explain potential expenses. There was no second facility representative witness annotation on the ABN having attested to witness the provision and refusal per facility policy.On 2/26/26 at 10:04 AM, the Administrator reported they did not have any additional documentation to provide (including additional NOMNC notices) and also confirmed there were no SNFABN notices for residents that remained in facility.According to the facility's policy titled, Advance Beneficiary Notices dated 10/30/2023: .It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage.The current CMS-approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative).For Part A items and services, the facility shall use the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN).A Notice of Medicare Non-Coverage (NOMNC).shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their Quality Improvement Organization (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(QIO).This notice is used when all covered services end for coverage reasons.An exhaustion of benefits is not considered a termination for coverage reasons.The Social Service Director or designee is responsible for issuing Part A notices.The facility shall issue a notice each time, and as soon as, it makes the assessment that Medicare payment certainly or probably will not be made.Beneficiary refusals to sign.Have a second facility representative witness the provision of the ABN and the beneficiary's refusal to sign and sign an annotation on the ABN attesting to having witnessed said provision an refusal.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit a notification of transfer to the state ombudsman's office for one resident (R141) of one resident reviewed for hospitalization.Findings include:On 2/24/26 the medical record for R141 was reviewed and revealed the following: R141 was initially admitted to the facility on [DATE], transferred to the hospital on [DATE] and had diagnoses including Congestive heart failure and Chronic obstructive pulmonary disease A review of R141's progress notes pertaining to their hospitalization revealed the following:11/27/2025-12:26 Progress Note-General: Pt (patient) observed to be extremely lethargic and confused, writer assessed pt upon assessment BP (blood pressure) 118/62, 78 HR (heart rate) RR (respiratory rate)14 Blood sugar 183 and 89% o2 on oxygen via nasal cannula. NP (Nurse Practitioner) contacted and gave order to transfer pt to [local hospital] 911 . On 2/24/26 at approximately 8:26 a.m., a request for documentation that notifications of transfer/discharges sent to the State Long term care Ombudsman's office was made from the Administrator for transfers/discharges during November and December 2025. On 2/25/26 at approximately 11:42 a.m., during a conversation with the facility Administrator, the Administrator was queried regarding the ombudsman's notifications for residents who are transferred to the hospital. The Administrator reported that they had not been sending notifications of transfers/discharge to the State Ombudsman's office. The Administrator indicated that the Social Services Department was responsible for sending the notifications to the Ombudsman's office, but none had been completed for 2025 and they had started in 2026. On 2/25/26 at approximately 11:45 a.m., Social Worker C (SW C) was asked if they had any documentation that they had sent notification of transfers/discharges to the State Long Term Care Ombudsman's office for November and December 2025 and they indicated they did not complete the notifications for the requested time period and had started in 2026 to send notifications. No documentation that the notice of transfer to the hospital for R141 had been sent to the Ombudsman's office was provided by the end of the survey.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASARR) Level II evaluation (community mental health assessment) was completed and implemented within the resident's plan of care for one (R3) of one resident reviewed for PASARR. Findings include:Review of the clinical record revealed R3 was admitted into the facility on 7/16/25 (from another nursing home) with diagnoses that included: adjustment disorder with mixed disturbance of emotions and conduct, borderline personality disorder, bipolar disorder in partial remission most recent episode mixed, other specified depressive episodes, bipolar disorder, current episode mixed, severe, with psychotic features, and mood disorder.According to the Minimum Data Set (MDS) assessment dated [DATE], R3 had intact cognition and exhibited verbal behavioral symptoms directed towards others which occurred one to three days.According to the MDS assessment dated [DATE], R3 was marked as No for Is the resident currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability or a related condition?.Review of R3's level I (3877 form) dated 6/5/25 completed by the resident's previous facility documented, Bipolar disorder, current episode mixed, severe with psychotic features, borderline personality disorder, adjustment disorder with mixed disturbance of emotions and conduct; prescribed olanzapine 5 mg (milligram) tablet, haloperidol 5 mg tablet, divalproex sod dr 500 mg tab.Further review of R3's clinical record revealed there was no documentation that identified if a level 2 evaluation had been completed (comprehensive mental health assessment required to be completed prior to admission unless exempted).On 2/24/26 at 8:30 AM, an interview was conducted with the Social Service Director (SSD ?C'). When asked to explain the process for ensuring the required PASARR documentation was completed and available for review, SSD ?C' reported the admissions department usually gets the paperwork. When asked if they reviewed to ensure that was completed, SSD ?C' reported sometimes they did. When asked if that had been done for R3, SSD ?C' reported they guessed it was done by the social worker at her previous facility. SSD ?C' was asked to review R3's clinical record to see if that information might have been in another location and verified there was none available in R3's current clinical record. SSD ?C' was asked who had access to the computerized PASARR system to verify assessments were completed or submitted when needed and they reported they were the only person that had access to that system currently.On 2/24/26 at 9:20 AM, SSD ?C' reported they located R3's level II evaluation and they uploaded it into the electronic clinical record. When asked if they had identified any recommendations, they proceeded to review the level II document and was unable to offer any further explanation. When asked to clarify who was responsible to ensure the PASARR documentation was available upon admission, SSD 'C' reported that was usually admissions. When asked if the social service department reviewed that as part of their process even if a resident transferred from another facility, SSD ?C' reported they should have and was unable to offer any further explanation.Review of the Level II PASARR evaluation that was uploaded into the clinical record on 2/24/26 at 9:13 AM documented, in part: .Bipolar I disorder, Current or most recent episode unspecified-Primary .Alcohol use disorder, Moderate-Secondary .Cocaine dependence, uncomplicated-Secondary .Specify Mental Health Services (Other Mental Health or Specialized Services) to be provided: Nursing Home Mental Health Monitoring, Individual Therapy, Psychiatric Medication Review, Psychiatric Follow-up, Psychiatric Consultation .Requires Re-Evaluation in 364 Days .Reviewer's Recommendation Please pursue less restrictive placement when consumer's medical and physical status improves enough to safely do so .Specialized Mental Health Services: (X)Yes .[R3] is a [AGE] year-old Caucasian female who admitted to [name of other nursing facility] on May 28, 2025. [R3] has a long history of mental illness, and she is diagnosed with F31.9 Bipolar disorder. She requires ongoing mental health services. It is recommended that [R3] (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remain at her current placement where she can continue to receive the appropriate care for her mental, physical, and medical health needs. She seems to have some difficulty adjusting to the nursing facility. Therefore, it is also recommended that she receives specialized mental health services from the [community mental health] social worker in the form of nursing home monitoring and advocacy as needed. It is also recommended that she continue to receive mental health services from [contracted psych services]. Her services should include psychotropic medication, medication management, and therapeutic support to address her agitation, mood swings, and depression as well as other symptoms that may be present. [R3] should be encouraged to participate in the nursing facility's recreational activities for moral support and to increase her social skills . There was no documentation available in the clinical record that identified that R3 had been followed by social work from NSO.Further review of R3's care plans and social service assessments and/or progress notes revealed the above recommendations were not included.According to the facility's policy titled, Resident Assessment - Coordination with PASARR Program (Michigan) dated 10/30/2023 documented, in part: .This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder (MD), intellectual disability (ID), or a related condition receives care and services in the most integrated setting appropriate to their needs.PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority this includes annual reviews and change of condition.Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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. LPN A failed to verify R65's current Ativan count and failed to document the dose they removed on the controlled count sheet. LPN A was observed to have prepared and administered three additional residents' morning medications, without signing out the Ativan dose administered to R65. 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. 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. 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. No further explanation or documentation was provided by the end of the survey. 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. 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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm 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. 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 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. 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. There was no additional information provided by the exit of the survey

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews the facility failed to ensure the coordination of a Cardiology appointment and failed to communicate with the legal guardian for one (R9) of one resident reviewed for the coordination of medical appointments. Findings include:On 2/23/26 at 12:54 PM, a telephone interview was conducted with the guardian for R9. The guardian reported they drove to R9's cardiologist appointment on 2/19/26 for a pacemaker follow up. The facility staff did not ensure that R9 attended their appointment. The guardian expressed their frustration that the facility staff did not notify them before they traveled to another city to meet R9 for their appointment.A review of the medical record revealed R9 was admitted to the facility on [DATE], with diagnoses that included a presence of a pacemaker and dependence on renal dialysis.On 2/23/26 at 10:11 AM, R9 was observed in a geri chair. A brief interview was conducted with the resident.A review of the medical record revealed no documentation on why R9 missed their appointment on 2/19/26.On 2/25/26 at 11:51 AM, an interview was conducted with Unit Secretary (US) K (the facility staff responsible for scheduling the resident appointments) and US K was asked about the Cardiologist appointment for R9 on 2/19/26. US K initially stated the appointment was cancelled but then stated that the resident's MRI (Magnetic Resonance Imaging) appointment was the appointment that was cancelled. When asked why R9 did not make it to the Cardiologist appointment on 2/19/26, US K stated the transportation did not pick up the resident as scheduled. US K was asked if anyone had informed R9's guardian of the cancellation and US K stated they found out that transportation never showed up to take R9 to the appointment after the resident was scheduled to be there. US K stated they did not speak to the family at that time.On 2/25/26 at 1:18 PM, Unit Manager (UM) L (the nurse assigned to R9 on 2/19/26 dayshift) was interviewed and asked why R9 missed their cardiologist appointment on 2/19/26. UM L stated the transportation company arrived that day to take R9 to their appointment, but they could not find paperwork for the appointment. UM L explained all appointments are usually written on the communication board and there were no appointments noted for R9. UM L then stated US K informed them that the appointment was cancelled. UM L stated about thirty minutes after that a second transportation company came to transport R9 to the appointment, and they informed them the appointment was cancelled. When asked if they informed R9's guardian that was meeting them at the Cardiologist appointment, UM L stated they did not talk to the guardian.On 2/25/26 at 1:01 PM, the Administrator was interviewed and asked about the miscommunication amongst the facilities departments when it pertained to R9 appointment and the lack communication with the family/legal guardian. The Administrator acknowledged the concern and stated they planned to follow up with the nurses.No further explanation or documentation was provided.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure appropriate catheter care was provided for one resident (R6) of one resident reviewed for indwelling catheters. Findings include:On 2/23/26 at approximately 10:44 a.m., R6 was observed in their room, sitting up in their bed. R6 was observed to have an indwelling catheter with their catheter bag touching the floor and the tubing extended/taut. R6 was queried if they had any pain from the catheter tube pulling and they reported they did. Further observation of R6's catheter tubing revealed no method of securing the tubing to prevent pulling on the genitals. On 2/24/25 at approximately 10:26 a.m., R6 was observed in their room with Nurse E. R6's catheter tubing was observed to contain cloudy urine. R6's drainage bag was observed to be crumpled up in the privacy bag with urine unable to flow freely into the bag. Nurse E was queried to show R6's catheter securement device and they indicated that R6 did not have one, and they would have to get them one to prevent pulling on the genitals. On 2/24/26 the medical record for R6 was reviewed and revealed the following: R6 was initially admitted to the tacitly on 12/20/24, last readmitted on [DATE] and had diagnoses including Urinary tract infection and Bell's Palsy. A review of R6's MDS (minimum data set) with an ARD (assessment reference date) of 1/29/26 revealed R6 needed assistance from facility staff with their activities of daily living. R6's BIMS score (brief interview for mental status) was eight indicating moderately impaired cognition. A review of R6's care plans revealed the following: Focus-Resident has a need for indwelling catheter related to obstructive uropathy Date Initiated: 11/26/2025 Revision on: 02/09/2026 . A Physican's order dated 1/15/26 revealed the following: Change catheter securement device every night shift every 7 day(s) for management routine AND as needed for loose or soiled device. A review of R6's February 2026 treatment administration record (TAR) revealed the last administration of R6's catheter securement device was on 2/19/26. On 2/25/25 at approximately 12:55 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the standard of practice for ensuring appropriate catheter care and indicated that residents should have an anchor on to prevent pulling of the tubing on the genitals. On 2/25/26 a facility document pertaining to catheter care was reviewed and revealed the following: Policy: t is the policy of this facility to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infections, while maintaining their dignity and privacy. Catheter care may be provided by the nursing assistant and/or licensed nurse 1. Catheters should be secured to prevent pulling and damage to the urethral meatus. This may be accomplished by: a. Utilizing the appropriate drainage device (leg bag or catheter bag) b. Leg strap c. Velcro strap d. Linen/clothing clamp e. Adhesive securing device .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **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, Current behavior status, Things that make you become anxious/agitated, Things that calm or soothe you, What are your comfort foods/drinks when (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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? (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to ensure residents received a clear understanding of the facility's binding arbitration agreement for three (R60, R103 and R152) out of 72 residents reviewed for Binding Arbitration. Findings include: A review of the facility Policy titled, Binding Arbitration Agreements (7/28/2020) documented, in part: .Policy: This facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration.Binding Arbitration is a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship.the decision is final, can be enforced by a court, and can only be appealed on very narrow grounds.When explaining the arbitration agreement, the facility shall:. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands.Ensure the resident or his or her representative acknowledges that he or she understands the agreement. The facility provided a document titled, Document Completion Tracking- Resident Status: Current LAST 12 MONTHS. The document contained a section that confirmed residents who had agreed to Alternative Dispute Resolution (ADR) Agreement. Of the 106 residents listed on the document, 72 residents were noted as agreeing to ADR. During the Survey, a sample of residents were interviewed regarding whether they recalled entering into the Alternative Dispute Resolution/ Binding Arbitration agreement and how it was explained to them. R60On 2/25/26 at approximately 1:19 PM, R60 was observed lying in bed. R60 was asked if they remembered signing and agreeing to Binding Arbitration. R60 reported they did not recall signing the document and was not familiar with what Binding Arbitration meant. When told the facility agreement they signed would not allow them to resolve any disputes against the facility via a judge, jury and/or trial, R60 noted that if that was told to them, they never would have agreed to it. A review of R60's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: acute respiratory failure and depressive disorder. A review of R60's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (intact cognition). A review of their ADR Agreement (7/7/25) had electronic initials signed throughout the document including the last statement that read You acknowledge and agree that you have fully read, understand and are voluntarily entering into this agreement. There was a box marked X that noted the resident declined to sign the document. R103On 2/25/26 at approximately 1:25 PM, R103 was observed in their room. R103 was asked if they remembered signing and agreeing to Binding Arbitration. They reported that they did not recall signing it. When told the facility agreement they signed, they would not allow them to resolve any disputes against the facility via a judge, jury or trial, R103 noted that they would not have agreed to it. A review of R103's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: congestive heart failure, type II diabetes and bipolar disorder. A review of R103's MDS noted the resident had a BIMS score of 15/15. Their ADR document (dated 1/30/26) noted that R103 consented to the ADR Agreement via an electronic signature. There were no electronic signatures indicating the agreement was read to the resident. R152On 2/25/26 at approximately 9:00 AM, it was reported that R152 had agreed to a Binding Arbitration on 2/23/26. When a surveyor explained that signing the agreement prohibited them from addressing any disputes via a judge, jury and/or trial, they reported that that had never been explained to them and the only explanation they could recall was handling disputes under $20,000.00 in the facility and did not recall signing any documents. A review of R152's ADR document the agreement started on 2/19/26 however, was electronically signed on 2/23/25. There was no actual signature and nothing to indicate the terms of the agreement was fully explained. It should be noted R152 did ask to sign another agreement that noted they did not consent to Binding Arbitration (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after being interviewed by the surveyor. On 2/25/26 at approximately 2:33 PM, admission Director (AD) O was interviewed about the facility's Binding Arbitration agreements and the 72 residents who had agreed to it in the past 12 months. AD O explained that when residents enter the facility there is a large packet of documents that they go through with the residents. The last document in the packet is the Binding Arbitration agreement. AD O reported that they ask the resident would they arbitrate a dispute in house or outside for a dispute less that $50,000.00. When asked what their understanding of Binding Arbitration meant for the facility residents, they noted that Binding means they have no option to change what they signed. When asked if they explained to the residents that they are bound to an arbitration and would not be able to dispute in court with a judge and/or jury, AD O reported that they did not have a complete understanding as to binding.