STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235504	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springcreek Rehabilitation and Nursing Center	130 Sand Creek Highway Adrian, MI 49221

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Through observation, interview and record review the facility failed to ensure three residents (R1, R7 and R22) of four were bathed, had their hair washed, had their facial hair shaved to maintain the highest practicalable physical, emotional and psychological wellbeing.Findings IncludePertains to Intake #2728007Resident #1 (R1)Review of the medical record reflected that R1 was admitted to the facility on [DATE]. Diagnoses of chronic obstructive pulmonary disease with lower respiratory infection, weakness, presence of vascular implants and grafts, disorder of the brain, dementia, abnormalities of gait and mobility, colon cancer with a colostomy bag, anxiety and depression.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2025 revealed R1 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively impact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R1 needed substantial assistance with showering and personal care. R1 was maximal assistance on toileting, showering, dressing lower body, sit to stand and transferring from one surface to another.During an observation and interview on 03/24/2026 at 9:47 AM, R1 stated sometimes the staff shave the hair on my face and sometimes they do not. Observation of long hairs hanging off her chin at least 1 long. Writer asked if she preferred to have the chin hairs shaved. R1 stated yes, she does like her chin shaved.During an observation and interview on 03/25/2026 at 10:41 AM, R1 still had facial hair on her chin and stated tomorrow was her bath day.Record review of the care plan stated R1 needed physical assist by 1 staff with personal hygiene; I often need staff to shave whiskers on my chin and set-up assist for oral care. According to the task sheet, the facility staff had not given her a bath in the last 30 days.During an observation on 03/25/2026 at 1:05 PM, R1 still had chin hair longer than 1 .During an interview on 03/25/2026 at 1:10 PM, CNA Z stated R1 got showers on Monday and Thursdays. CNA Z stated when R1 refused her shower, they filled out a shower sheet, they ask her 3 times, then the nurse will ask after that. Writer asked about her facial hair and CNA Z stated that those last couple of months, she hadn't asked to have them shave her chin hair. Writer shared that R1 did in fact mention she wanted the hair shaved on her chin. CNA Z stated that she would take care of that today. Record review shows that R1 has not had a shower or bed bath in the last 30 days. Nor has her hair been washed. During an interview on 03/25/2026 at 4:06 PM, LPN/UM E was asked for shower sheets on R1. Requested Shower sheets from LNA A again at 4:42pm.During an interview on 03/26/2026 at 7:33 AM, LNA A still has not provided the requested shower sheets from yesterday. Requested again at 7:45 am and received them at 8:15am, 2 shower sheets for the last 30 days for R1. Dated 03/12/26 and 03/19/26. Both shower sheets provided documented resident was not shaved on either shower day. They did not provide any other documentation as to why they were not given a shower or refused one in the last 30 days.During an interview on 03/26/2026 at10:25 AM, DON B stated the CNA didn't know how to put in a prn shower, stated when they moved her from bed 1 to the bed 2, they didn't change her task itself on what days she was to receive her showers, CNA's would put NA because nobody changed the days under that task. DON B stated R1 moved from bed 1 to bed 2 back in June 2025. DON B stated the staff was going off of her old schedule. Writer asked DON B that nobody noticed this or noticed R1 was not getting her showers? DON B stated apparently not.During an interview and observation on (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/26/2026 at 3:28 PM, R1 was sitting in her wheelchair in her room coloring, appeared to have had a shower today, facial hair was shaved, R1 stated she really didn't like the hair on her face, but it's shaved now. Writer stated that task was in her care plan on the correct days and should have been done with her showers. Resident #7 (R7) Review of the medical record reflected that R7 was admitted to the facility on [DATE] and signed onto hospice 02/12/2026.Diagnoses of Huntington's disease, dementia, other disorders of the muscles, emotional deficit related to cerebrovascular disease, protein-caloric malnutrition, weakness and repeated falls.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/26/2025 revealed R7 had a Brief Interview of Mental Status (BIMS) of 10 (moderate cognitive impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance revealed R7 was dependent on toileting, showering, lower body, sit to stand and transferring from one surface to another with a mechanical device.Record review revealed R7 was admitted on hospice services 02/12/26. Binder contains no certification paperwork, no care plans, no medication list, nor a filled-out calendar with projected visits scheduled.During an interview on 03/24/2026 at 2:40 PM, LPN GG stated she didn't know where this required information would be. Writer asked other facility staff and was told there was a binder behind the nurses' station, labeled said hospice agency that would contain all required documentation. LPN GG went through the hospice binder to find a blank calendar, no nurse visit schedule, no CNA visit schedule, no Social Worker schedule, no Spiritual schedule, no volunteer schedule either, no certification copied to the binder, no medication list.During an interview on 03/25/2026 at 11:45 AM, Hospice Registered Nurse (RN) HH stated they usually put their schedule on the calendar, as she looked, writer stated there was nothing written on the calendar. Writer asked RN HH for the care plans, certification, medication list, filled out calendar of projected visits. RN HH went into her computer and told this writer the CNA is coming on Mondays and Wednesdays same for the nurse, no visits scheduled for social worker. Chaplin is 2 times a month. RN HH stated she would have the office send the information required.Record review revealed a R7 revealed Hospice/Facility Coordinated task plan of care, SN to start 2 x a week, week of 02/12/26 and CAN 2 times a week, week on 02/16/26, Activities listed for CNA- bathing, oral care, hair care and toileting. SN to monitor pain and symptoms, vital signs, symptom management, bowel monitoring. No signature on the bottom of the page by hospice staff, facility or family member, labeled coordination note.Record review revealed no documents scanned to the EMR from hospice as required by Medicare. During an interview and observation on 03/25/2026 at 1:13 PM, CNA Z stated hospice comes in and gave R7 a shower and bed bath every week. Writer asked CNA Z which days the facility CNA's give him baths or showers. CNA Z stated they don't, once the residents are on hospice, they do all of the personal care like showers and baths, unless the residents need one or the hospice CNA won't be coming in. CNA Z stated residents are marked for 2 showers or baths a week, pointing out the schedule on the wall of the linen closet. Stated again that when residents are on hospice, they do not give showers or baths, hospice does all of them and we do not do them unless they are soiled. During an interview and observation on 03/25/2026 at 3:49 PM, LPN/UM E and LPN/UM H stated hospice certification, care plan, medication list, calendar and visit notes should be in the hospice book/binder. LPN/UM H went out to the nurses' station to get the binder. Both LPN/UM E and LPN/UM H looking through R7s information, there was not a certification provided, no medication list, no care plans, the calendar with disciplines visits planned out, it was blank. Writer asked where the visit notes would be as they are not in PCC, the electronic medical record for R7. LPN/UM E stated there is a section where they tell what they did that visit. Writer asked if that was the visit note or a communication note. LPN/UM stated she wasn't sure. LPN/UM E stated shower days for R7 were Wednesdays and Saturdays by the facility CNAs. LPN/UM E stated hospice showers looked like Mondays and Wednesdays.Record review revealed R7 did not receive a shower or bath from the facility CNAs in the last 30 days, all showers were given by the hospice CNAs.During an interview on 03/25/2026 at 5:11 PM, CNA FF stated when the resident was on hospice, hospice CNAs do the showers, but if they do not come in for whatever reason, then the facility CNAs will provide that (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care.Writer requested R7s shower sheets on 03/25/26 at 4:42pm.Have not received the shower sheets requested on R7 as of 03/26/26 at 7:15am, requested shower sheets from LNA A on R7 again at 7:45am.Writer was given 3 sheets of hospice coordination notes showing the hospice CNA gave R7 showers or baths on 02/20/26, 03/04/26, 03/09/26, 03/11/26, 03/22/26 and 03/25/26. Facility CNAs did not provide any showers or baths or any documentation to support why they did not give any showers, baths during the last 30 days.During an interview on 03/26/2026 at10:29 AM, DON B stated they get the admission for hospice to business office. Hospice orders are put in by LPN/unit manager H. DON B stated depending on the resident, a CNA comes in spend time with him, personal care provided, get them ready for the day if it's a morning visit. Writer asked DON B how she knows who is coming in that day? DON B stated they had a book they sign in saying what they did for that visit. DON B stated she expected facility CNAs to provide care regardless of if hospice is on board. DON B stated she will reeducate them. Writer asked DON B who sets up the Hospice Binder? DON B stated when they send them/facility the care plan, notes, contact information. DON B stated she knew R7s information. DON B stated hospice staff either bring it in or email it to her and the ward clerk, and it will get scanned for the electronic chart or the binder. Writer asked how often they email the facility the visit notes, care plans, completed calendar, certification and medication list. DON B stated definitely not daily or weekly, looks like monthly, some of the notes were emailed from 02/13/ to 03/04, but was not printed, it should go under the Miscellaneous tab.Record review did not reveal any Hospice documentation scanned into the electronic medical record, nor the paper chart Binder provided by hospice, that was sitting in someone's email account. Resident #22 (R22)Review of the medical record reflected that R22 was admitted to the facility on [DATE]. Diagnoses of hemiplegia and hemiparesis following a stroke, lack of coordination, disorder of the muscles, cervical disc disorder of cervical region, fistula of the stomach and duodenum, difficulty in walking and major depression.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/2025 revealed R22 had a Brief Interview of Mental Status (BIMS) of 10 (moderately cognitively impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) R22 was dependent of all care, toileting, showering, dressing lower body, sit to stand and transferring from one surface to another.During an observation and interview on 03/24/2026 at 12:55 PM, R22 was lying back in her bed being fed breakfast by her husband. He brought in food from outside of the facility and she was enjoying it. Writer noted a buildup of plaque on her teeth, from not getting her teeth brushed. This was not a food build up from eating her breakfast. Writer also observed noticeable heavy facial hair on her chin and a mustache. R22 stated she had asked them to shave it off for her, until they told her they use the same razor on the residents. R22 told them she was not using the same razor as others. R22 had her husband bring in her electric razor from home, which sat on her over the bed table within site.During an observation on 03/25/2026 at 10:42 AM, R22 was resting with her eyes closed. Writer observed heavy facial hair present on her chin and a mustache. Electric shaver was still lying in the same place on her over the bed table. During an interview on 03/25/2026 at 1:19 PM, Certified Nursing Assistant (CNA) Z stated R22 had not had her facial hair shaved up until now. CNA Z added R22's husband brought in her electric shaver, must have been yesterday as she did not work yesterday and it wasn't there the day before. CNA Z added R22 is down for a bed bath today so she will shave her face. During an observation on 03/25/2026 at 3:19 PM, R22 was lying in her bed watching TV, her facial hair had been removed from shaving. During an interview on 03/25/2026 at 4:07 PM, Licensed Practical Nurse (LPN) AA stated when R22 came to the facility, she did not want her facial hair shaved. Writer asked LPN AA if it was on her care plan. LPN AA looking at R22's care plan and read aloud, staff were encouraged to shave her face as needed. Writer asked LPN AA if there was anything on the care plan stating not to shave R22's facial hair. LPN AA stated there was nothing about R22 not wanting to have facial hair shaved off as it is on the care plan. Record review revealed R22 was listed on the shower sheet for showers/bed baths on Wednesdays and Saturdays. It also revealed that R22 did not receive any bed baths or showers in the last 30 days according to the shower sheets (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided to this writer. On 02/21/26- R22 refused care, on 03/12/26- R22 also refused care. No further documentation to support R22 was approached again and asked about taking a shower or in the CNA had reported this to the nurse.During an interview on 03/26/2026 at 10:16 AM, Director of Nursing (DON) B stated the expectation was to provide R22 showers or bed baths two times a week. DON B also stated when R22 refused, they encouraged her to allow care, R22 didn't always allow care, she refused to allow CNAs to shave her facial hair. Writer asked DON B if it was care planned. DON B stated she could not find anything at the moment, writer noted it was in the care plan to shave facial hair as needed. DON B then stated it read to encourage R22 to allow shaving. Under the two shower refusals sheets, R22 didn't refuse shaving, just showers or baths. DON B stated the refusal was on the shower sheets, she looked at yesterday, only two showers or bed baths offered, nothing documented in progress notes to reflect R22 refusing her shower/bed bath, it R22 was reapproached later or if it was reported to the nurse working on the floor that day. DON B stated there was a progress note on 02/16/26- R22 offered to be shaved and she said no from the wound care nurse. No follow up after this progress note was put in. During an observation and interview on 03/26/2026 at 2:30 PM, R22 stated they shaved her facial hair today and it's a lot better now. R22 also stated it will be a lot easier to keep it maintained now. R22 smiled sharing this with the writer and noted the plaque build up on her teeth was still visible.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2803162 Based on observation, interview and record review the facility failed to prevent an avoidable fall as well as conduct a thorough root-cause analysis investigation into falls for five residents (R3, R17, R71, R98, and R106), of six residents reviewed for falls resulting in transfer to hospital and major injuries including fractures and subdural hematoma. Findings include: R3 Review of the medical record reflected R3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included unsteadiness on feet, lack of coordination, vascular dementia, and displaced subtrochanteric fracture of right femur. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/23/26, reflected R3 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 3/26/25 at 9:12 AM, R3 was observed in a common area seated in a wheelchair. A fall mat was observed in R3's room. Review of a Progress Note dated 6/4/25 stated R3 was discovered face down with left shoulder pinned under roommates' bed .Resident has bruise to his left eye and forehead. Resident being sent out to the ER (Emergency Department) . The Investigation Summary Note for the fall that occurred on 6/4/25 stated nurse description of the event is reported as resident (R3) called for help verbally and when staff entered resident was face down on the floor with his shoulder under roommates' bed. Resident was unable to give a description of what happened . new orders were to be sent out to ER for evaluation. Root cause to be determined to be resident was out earlier in the day for a cystoscopy and returned with a foley cath (catheter) .and was sent out to the ER earlier for gross bleeding around the catheter post cystoscopy and could have led to him being tired and weak. Review of a Progress Note stated that although R3 was sent to the hospital for the fall, R3 was admitted to the hospital for sepsis (a life-threatening condition that happens when the body's immune system has an extreme response to an infection, causing organ dysfunction) secondary to a urinary tract infection, metabolic encephalopathy (when the brain has trouble working because of a chemical, or metabolic, problem in the body), rhabdomyolysis (muscle breakdown) and COVID. Review of an Incident Report dated 11/29/25 at 5:00 AM stated that R3 was found on the floor in front of his bed on his stomach. Patient (R3) had shoes on. The intervention was to, again, add nonskid strips on the floor next to the bed. The predisposing environmental factors did not indicate that the floor was wet/slippery at the time of the fall. Review of a Progress Note dated 1/20/26 revealed resident observed on floor next to roommates bed laying on his back with laceration to right of right eyebrow. resident assessed and no other immediate signs of injury or pain noted. Nasal cannula replaced and ambulance called for transport to ER for treatment of laceration . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note dated 1/20/26 indicated the hospital R3 was sent to reported R3 was admitted for a fracture to the right hip and a UTI (urinary tract infection). R3 readmitted to the facility on [DATE]. Review of the incident report dated 1/20/26 revealed R3 was observed on the floor in his room. His mental status was noted to be alert, disoriented and confused. It was noted on the incident report that he had a recent illness and weakness. On 3/26/26 at 10:26 am, Registered Nurse F stated that he was working on 1/20/26 when R3 sustained the fall. RN F reported that R3 had recently been ill and had been staying in bed mostly for days leading up to his fall. Review of a Progress Note dated 2/12/26 at 7:07 PM revealed resident (R3) experienced a witness [sic] fall at 1745 (5:45 pm) by the nurses station. Witness observed resident standing up from his chair and began walking while holding his pants. Witness attempted to assist resident by bringing a wheelchair and reaching for his hand, however, resident turned and did not make it into the wheelchair and subsequently fell . In an interview on 03/27/2026 at 9:40 AM, Director of Nursing (DON) B stated that the Interdisciplinary Team meets every morning to discuss falls, review care plan interventions, review the incident, and interview staff to review the situation surrounding the fall. Regarding the fall that occurred on 6/4/25, DON B stated R3 was experiencing weakness related to sedation from a procedure earlier in day. DON B reported the intervention implemented was the addition of nonskid strips to R3's floor, however DON B acknowledged increased supervision, or more frequent checks would have been a more appropriate intervention given R3's condition at that time. Review of R3's care plan revealed that nonskid strips were not added to the care plan as an intervention. During the same interview DON B stated that R3 sustained another fall on 11/29/25 where he was observed on the floor of his room. The intervention for this fall was to again, add non-skid strips to R3's floor, DON B was unable to confirm whether non skids strips were in place at the time of his 11/29/25 fall. DON B further stated that prior to the fall that occurred on 1/20/26, R3 had been ill, experienced increased weakness and remained in bed for several days not wanting to get up. Treatment was initiated and R3 was feeling better but then attempted to try and get up independently and fell. R3 was sent to the hospital and found to have sustained a hip fracture. Fall interventions included adding a fall mat and ensuring R3's bed was in its lowest position. These interventions are protective in nature and do not prevent falls, as they do not address the underlying causes of R3's reoccurring falls in his bedroom. Several requests for further fall investigations including root cause analysis investigations for the reoccurring falls went unfilled. After R3's fall with fracture on 1/20/26, it was determined that a significant change MDS was required due to the decline in Activities in Daily Living along with the fracture. Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R4106 was a [AGE] year-old female admitted to the facility on [DATE], with recent re-admission 3/24/25 related to acute intercranial hemorrhage post fall, and other diagnosis that included dementia, frequent falls, and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	anxiety. The MDS reflected that R106 had a BIM (assessment tool) score of 3 which indicated her ability to make daily decisions was severely impaired. During an observation on 3/24/2026 at 10:47 AM, R106 was laying in bed with eyes closed and what appeared to be bloody contusion to right forehead area. During an observation on 3/24/2026 at 1:22 PM, R106 was independently ambulating in room and appeared very unsteady on feet. R106 exited room and entered the hall, observed by staff, wearing a hospital gown repeatedly touching right forehead area that appeared to be contusion with bloody matted hair. Staff did not attempt to assist resident. Review of R106 Provider Progress Note, dated 3/14/26, reflected, History Of Present Illness: Patient is an [AGE] year-old female with a history of dementia, frequent falls. Review of R106 Progress Note, dated 3/14/26 at 12:46 p.m., reflected, Pt[patient] is alert to self Pt is on room air Pt has a hx[history] of stroke, syncope, AFIB[atrial fibrillation], delirium Pt was admitted to hospital for cellulitis Pt has clear speech, wakes to voice Pt is a heavy 2 Pivot assist no walking. won't follow commands. Pt is passive during the day and sundown at night. Review of R106 Progress Note, dated 3/15/26 at 12:37 pm, reflected, pt home health aide providing care @ 1130. writer heard a loud bump. walked into to room to find pt tearful. writer asked if pt was in pain and if she hit her head, home health care said yes to hitting head, pt reported pain. home health aide said she was standing up doing care and pt fell back onto bed and hit her head on the wall. 4cmx4cm goose egg noted to back of head.orders to send pt to [named] ER[emergency room] for eval and treat due to head injury and pt on blood thinners. Review of R106 Nurse Progress Note, dated 3/15/26 at 3:08 p.m., reflected, pt returned from ER. Review of R106 Nurse Progress Note, dated 3/16/26 at 6:27 p.m., reflected, Resident has been up all night, trying to crawl out of bed, not sitting sill. Spouse was here till the middle of the night, but resident was still anxious and antsy. Staff have had to do 1:1 with resident due to resident not wanting to stay in her bed or her wheelchair. Review of R106 Nurse Progress Note, dated 3/19/26 at 2:02 a.m., reflected, Resident pacing up and down the hallways after her spouse left around 2230, resident is very unsteady on her feet and keeps grabbing at the side rails and treatment cart to keep herself upright. Staff have had to redirect resident multiple times as she keeps going into other residents' rooms. At one point, staff was doing 1:1 with resident and walking her up and down the hallway in a wheelchair. Resident seems anxious and doesn't respond well to redirection and will become aggressive or become more agitated. Staff will reapproach if that happens. Resident did eventually lay down and go to sleep with all safety measures in place. Review of R106 Event Progress Note, dated 3/19/26 at 12:48 p.m., reflected, Investigation Summary Note: Resident recently hospitalized for c/o worsening leg pain and treated for cellulitis to RLE[right lower extremity]. Resident has weakness, deconditioning secondary to advanced Dementia. Resident had a noted fall on 3/15/26. Nurse description of the event is reported as the nurse heard a loud bang from hallway, entered pts room. pts home health aide was in room giving care to pt, pt tearful. writer asked if pt fell, home health aide reported that pt was standing while receiving care and sat backwards on to bed and hit head on the wall. Resident could not give a description of the event r/t (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Dementia. Root cause has been determined to be that resident lost her balance when standing while receiving care from her home health aide and when she came to a rest on the bed, her head hit the wall, causing hematoma to the back of her head. Physician was notified and ordered to send to ER[emergency room] for eval. New intervention was husband was notified and explained that it was not necessary for residents' home health aide for provide care while resident is in this facility. Family in agreement with the current plan of care and care plan goal minimize risk for falls. (Interdisciplinary meeting noted completed 5 days after fall.) Review of R106 Nursing Progress Note, dated 2/24/26 at 12:28 a.m., reflected, Late Entry: Note Text: Resident observed in her room on the floor, floor was wet from possible spilled water, resident's brief was dry. bed was in the lowest position, call light was attached to edge of the bed and not used. Resident visibly bleeding from the right side and back of head. Review of R106 Nurse Progress Note, dated 3/24/26 at 7:15 a.m., reflected, Resident returned from ER, husband at bedside. resident is restless, up and down from bed and unable to express what she needs. writer asked her if she hurt and she brought her hand to her right side of her head and said no. Resident does have a red scab area noted to her right side of head from fall. Review of R106 Nurse Progress Note, dated 3/24/2026 at 7:16 a.m., reflected, Pt returned back to facility from CVH by ambulance. Moderate right frontal scalp hematoma. There is a left extra-axial slightly hyperdense fluid collection suggestive of subdural hemorrhage measuring 9-9mm with mild mass effect upon the left cerebral hemisphere. No shift of midline structures. There is small volume acute hemorrhage in the region of the left basal cisterns axial image. Review of R106 Event Progress Note, dated 3/25/2026 at 14:31 p.m., reflected, Investigation Summary Note: for [AGE] year resident with Dementia, hx[history] of falls, mitral valve replacement, A-fib, anxiety and insomnia. This Resident had a noted fall on 3/23/26. Nurse description of the event is reported as resident was observed in her room on the floor, floor was wet from possible spilled water, and the resident's brief was dry. bed was in a low position for safety while sleeping, call light was attached to edge of the bed and not used. Vitals obtained, resident visibly bleeding from the right side of her head and the back of her head, possible rib injury as well. Resident could not give a description of the event r/t her poor cognition. Root cause is resident has a misunderstanding of her limitations, is unsteady and restless. Resident was started on hydroxyzine 25mg at bedtime on 3/20 to help manage her anxiety symptoms of anxiety. Physician was notified and ordered to send to ER for eval was the immediate intervention. Resident returned, with orders to Monitor hematoma to right side of forehead for changes. IDT met and additional intervention was a floor mat was added next to the bed at night for safety. Husband was at the bedside when resident returned from the ER. During an observation on 3/25/2026 at 7:21AM, R106 was independently ambulating in the hall with unsteady gait and two nurses in area with no attempts to assist or redirect R106. Review of the Base Line Care Plan, dated 3/14/26, reflected R106 had a fall Care Plan that included, Resident has limited physical mobility r/t dementia.interventions; TRANSFER: 2-person pivot transfer. Review of the Care Plan, dated 3/18/26, reflected interventions that included, AMBULATION: The resident requires CGA [contact guard assist] x1 staff to walk without assistive devices.TRANSFER: CGA by 1 person for sit to stand transfers, dated 3/14/26. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Hospital Physical Therapy assessment, dated 3/13/26, reflected R106 required maximum two person assist sit to stand, chair to bed transfer, and ambulation. Review of R106 Radiology Report, dated 3/24/26, reflected R106 had CT scan of brain that included, Acute small volume subarachnoid hemorrhage in the region of the left basal cisterns with isodense left subdural fluid collection or hemorrhage measuring 8 to 9 mm in thickness with minimal mass effect upon the left cerebral hemisphere. Small right frontal scalp hematoma. During an interview on 3/25/2026 at 4:35 PM, Licensed Practical Nurse Unit Manager (UM) H reported had been a Unit Manager for about seven years. UM H reported if resident had a fall would expect nurse to complete a head-to-toe assessment of resident, start neuro assessments as needed, obtain vitals, continue to assess, notify physician and follow orders. UM H reported depending on situation resident transferred off floor to bed with mechanical lift and assessments continued. UM H reported nurse would complete Incident Report and attempt to determine cause of fall and add new interventions to Care Plans. UM H reported Interdisciplinary (IDT) Team meeting next day to discuss all falls including how resident fell, injuries if any, what were they doing to attempt determine root cause of fall and document in the Progress Notes. UM H reported nurses can add interventions to Care Plans and often MDS nurse C added additional interventions if needed and reported MDS C often completes fall investigations and IDT fall follow up notes. UM H reported R106 was a high risk for falls on admission 3/14/26 with score of 60 and verified over 45 was high risk for falls. UM H verified R106 had a Base Line Care plan for falls dated 3/14/26 that included two-person assist with transfers and reported would expect Care Plans to be followed. UM H reported R106 had fall on 3/15/26(day after admission) during caregiver assisted care with one non-staff member and fell and obtained posterior head injury and was transferred to the hospital. UM H verified R106 was on blood thinners. UM H was verified IDT meeting Progress note was completed 3/19/26 and was unable to explain four-day delay and reported team always discusses falls the next day after a fall. During an interview on 3/25/2026 at 6:05 PM, Director of Nursing (DON) B reported MDS C completed fall investigations. DON B reported R106 first fall on 3/15/26 was with private caregiver present and family was educated after fall that staff was responsible for providing care. No evidence that facility had provided education to private caregiver prior to fall was located or provided prior to survey exit. DON B reported R106 second fall on 3/23/26 at 11:50 p.m., when resident independently transferred and lost balance and fell and sustained head injury including subdural hematoma that required emergent transfer to hospital. DON B verified had provided surveyor with Incident/Accident reports that did not include complete investigation including witness statements as requested and reported would follow up. DON B verified R106 Care Plans indicated one person assist with ambulation prior to 3/23/26 fall and remain current intervention and reported would expect staff to follow Care Plans. During an interview on 3/25/26 at 5:20 p.m., Registered Nurse (RN) J reported was currently R106 nurse along with RN F who was her Preceptor. RN J reported was unsure if R106 required assistance for ambulation and reported R106 frequently ambulated independently and with staff and reported routinely ambulated most of the day. During an interview on 3/25/26 at 6:45 p.m., MDS C reported completed fall investigations including IDT fall follow up Progress Notes. MDS C reported R106 falls included witness statements. MDS C reported R106 ambulates all day including with husband during the day and reported R106 had poor safety awareness and was very impulsive. During an interview on 3/26/2026 at 3:43 PM, MDS C verified R106 was assessed to need two person (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	assist with transfers by nurse and was changed to one person contact guard on 3/18/26 reported that meant one-person hands-on assist. MDS C reported floor mat was added next to R106 bed after 3/23/26 fall. MDS C verified R106 fall on 3/23/26 fall happened in the doorway to hall. MDS C was queried if floor mat on floor by bed was an appropriate intervention for 3/23/26 fall and stated, maybe not the best for that situation but would need. MDS C reported R106 was very impulsive, up and down all day with poor safety awareness due to dementia. During a telephone interview on 3/26/2026 at 4:51 p.m., Licensed Practical Nurse(LPN) I reported was alerted by Certified Nurse Aid(CNA) staff that R106 had fallen on 3/23/26 shortly before midnight and as bleeding. LPN I reported had orientee working with her that evening and they returned to Hall C unit observed R106 on floor in doorway of room with feet towards door and head towards window of room, profusely bleedind from right temple area and back of head. LPN I reported other staff present and she went to Nurse station and called 911 and worked on paperwork to transfer to hospital and returned to R106 room. LPN I reported R106 was actively trying to get up off floor and CNA staff remained on floor with R106 until Emergency Medical Staff arrived. LPN I reported R106 had very poor safety awareness and often make LPN I very nervous when R106 walked independently. LPN I reported prior to R106 3/23/26 fall Care Planned interventions were low bed. LPN I reported a lot of the time staff were providing R106 1:1 assistance walking with R106 in the hall when they could but otherwise R106 ambulated independently whe staff were providing care to other residents. LPN I reported R106 was currently care planned to have contact guard with ambulation and the meant stand by assist with no need for hands on resident.(different that MDS C meaning of definition). LPN I reported R106 seemed to have nights and days mixed up and was often aware much of nights shift and reported R106 had slept most of the day on 3/23/26 prior to fall During a telephone interview on 3/26/2026 at 5:19 PM, Certified Nurse Aid(CNA) K reported witnessed R106 fall on 3/24/26 just before midnight. CNA K reported R106 exited room and attempted to close door behind her and fell into door and landed face first on floor. CNA K reported was close but unable to get to her in time prior t hitting the floor and R106 intently started bleeding from the front and back of head. CNA K reported resident kept trying to get up and then seemed to go in and out of conciseness while she was holding washcloth to head. CNA K reported LPN I and Nurse Orientee L were were first nurses who arrived after another CNA left unit to find notify them of fall. CNA K reported remained on floor with R106 until EMS arrived about 12:30 a.m. and reported seemed like a long time because fall occurred at 11:50 p.m. CNA K reported R106 also had knot on sternum and left rib appeared pushed out. CNA K reported R106 fall interventions prior to 3/23/26 fall were to attempt to keep R106 in chair but ambulated frequently on own and staff were required to supervise R106 during ambulation with no need to have hands on. CNA K reported no change interventions with exception of mat on floor was added. CNA K reported facility staff had not questioned her after this fall with exception of this surveyor about the fall and reported had completed a written witness statement at the time of the fall. (written statement not provided to surveyor after completed investigation had been requested.) CNA K verified typed witness statement appeared correct after reading aloud except had noted on written statement that nurses had woke R106 just prior to fall to administer Tylenol and reported R106 does not sleep well and R106 often gets out of bed after awaken for medications around midnight and paces halls. During a telephone call on 3/26/2026 at 5:39 PM, Nurse Orientee (NO) L reported was orienting with Preceptor with R106 fell on 3/23/26. NO L reported was on Hall D when CNA staff alerted nurses of R106 fall on Hall C memory unit. NO L reported they immediately went to R106 room and observed R106 on the floor with puddle of blood under her head bleeding from right front forehead and back head and reported R106 was on blood thinners. NO L reported another nurse also assisted after fall (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and she remained with LPN I who called 911 and worked on paperwork to transfer to hospital. NO L reported did not complete witness statement but CNA staff did and no facility staff had questioned NO L about R106 3/23/26 fall. NO L reported had overheard nursing staff tell EMS staff that R106 was on blood thinners. During a telephone call on 3/26/2026 at 5:47 PM, CNA M reported was working when R106 fell on 3/23/26 around midnight. CNA M reported nursing staff had woke R106 to administer medications and shortly after that R106 exited room and fell in doorway. CNA M reported R106 was always, floor pacing and was usually sleeping in bed. CNA M reported R106 front of right head and back of head was bleeding, quite a bit, and reported saturated 5 to 6 washcloths with blood holding pressure to R106 head. CNA M reported did complete written witness statement and was not questioned by facility staff about R106 fall. CNA M reported R106 had care planned interventions to keep clear path in room, bed low and toileted and after fall added mat on floor by bed. CNA M reported R106 self ambulates frequently but should have one person assist. Reported R106 walks independently in the hall when staff are providing care to other residents but otherwise try to keep eyes on R106. Resident #17 (R17) Review of the medical record reflected that R17 was admitted to the facility on [DATE]. Diagnoses of dementia, unsteady on her feet, weakness, muscle weakness, difficulty walking and cognitive communication deficit. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/25/2026 revealed R17 had a Brief Interview of Mental Status (BIMS) of 03 (moderately cognitively impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) R17 was partial to moderate assistance for toileting hygiene, showering, getting dressed, and putting on shoes. Section GG0120. Mobility Devices had walker checked off as yes in use, but wheelchair was checked off as no. During an observation and interview on 03/25/2026 at 2:00 PM, CNA EE was pushing a wheelchair down the hall without footrest on it from the dining room/activity room to R17's room as the nurse asked CNA EE to bring R17 back to take her medication. CNA EE stated they didn't have any footrest for R17, and she was trying to get her back to her room to take her medications. CNA EE continued to push R17 back to her room. During an interview and observation on 03/27/26 at 1020am, Regional Physical Therapist II stated nursing staff should be using a footrest if the resident is being pushed or needs assistance with getting from point A to point B. Regional Physical Therapist II stated CNAs do not need the therapy staff to get a footrest, they can come in and get it themselves. Regional Physical Therapist II pointed to 3 totes full of footrests and Regional Physical Therapist II stated he was not aware that they had a shortage or not enough footrest for residents. During an interview on 03/27/2026 at10:29 AM, DON B stated it would be the expectation that the CNA's use footrest when pushing a resident down the hall in a wheelchair. Resident #71 (R71) Review of the medical record reflected that R71 was admitted to the facility on [DATE]. Diagnoses of fractured right leg, repeated falls, heart failure, dementia, and lack of coordination. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/10/2025 revealed R71 had a Brief Interview of Mental Status (BIMS) of 99 (rarely understood) out of 15. Under section G0100, Activities of Daily Living (ADL) R71 was maximum assistance to dependent of all care, toileting, showering, dressing lower body. During an observation and interview on 03/25/2026 at 9:00 AM, CNA NN pushing R71 in a wheelchair down the hall with R71's feet dragging on the floor. No footrest was attached to the wheelchair, CNA NN stated they don't have enough footrest for all of the residents that need it, so they have to share them, still not having one on the wheelchair. During an interview and observation on 03/27/26 at 1020am, Regional Physical Therapist II stated nursing staff should be using a footrest if the resident is being pushed or needs assistance with getting from point A to point B. Regional Physical Therapist II stated CNAs do not need the therapy staff to get a footrest, they can come in and get it themselves. Regional Physical Therapist II pointed to 3 totes full of footrests and Regional Physical Therapist II stated he was not aware that they had a shortage or not enough footrest for residents. During an interview on 03/27/2026 at10:29 AM, DON B stated it would be the expectation that the CNA's use footrest when pushing a resident down the hall in a wheelchair. Resident #98 (R98) Review of the medical record revealed R98 was admitted with 10/22/2025 with diagnoses that included laceration of right lower leg, cerebral infarction (stroke), acute cystitis (inflammation of the bladder), heart failure, cognitive communication deceit, depression, restlessness and agitation, hypertension, abnormal posture, adult failure to thrive, vascular dementia, atrial fibrillation, chronic pain, osteoarthritis (degenerative joint disease), atherosclerotic heart disease (plaque build-up in artery walls), and hypothyroidism (low thyroid hormone). Review of R98 Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/25/2025, revealed a Brief Interview of Mental Status (BIMS) of 05 (severe cognitive impairment) out of 15. Section GG-Functional Abilities of the MDS with the same ARD revealed R98 required set up or clean-up assistance for eating. R98 was discharged to the hospital 12/05/2025 related to an injury incurred during a fall and did not return to the facility. Review of R98's medical record revealed progress note, entered 12/03/2025 at 06:37 a.m. CNA (Certified Nursing Aide) report to RN (Registered Nurse) that resident was observed on the floor. RN went to room to assess resident. Resident was sitting on the floor, sitting up next to the bed, leaning against the bed. Resident was observed for new injuries, pain, ROM (Range of Motion) assessed. Neurochecks (Neurological checks) initiated. VS (Vistal Signs) obtained. Resident was placed back into bed; bed was lowered to lowest position. MD (Medical Doctor), Nurse Management on-call notified. Review of R98's plan of care revealed new intervention, date initiated 12/03/2025 but with a created date of 12/08/2025 (after the date of discharge), Bed in lowest position when not performing task. Review of R98's medical record revealed a progress note entered 12/08/2025 at 10:34 a.m. entitled Investigation Summary Note: . had a noted fall on 12/3/25. Nurse description of the event is reported as cna (certified nurse aide) reported to RN (Registered Nurse) that resident was observed on the floor in her room next to the bed with back against the bed, had her grip socks on, brief was dry, bed was in a low position but was not in the lowest position, call light was in reach but not in use. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident could not give description of what happened or what she was trying to do. Root cause has been determined to be she possibly rolled out of bed. No injuries noted, neuros were initiated, and resident was placed back into bed with be in the lowest position, call light in reach and fluids offered. Resident continues Therapy Services, and her sitting balance has been improving. IDT (Interdisciplinary met and care plan had been reviewed and updated. Review of R98's medical record revealed progress note, entered 12/05/2025 at 23:21 (11:21 p.m.), Client observed on floor at 2045 (08:45 p.m.) with excessive bleeding from face, hematoma (bruising) to right side of forehead, dislocation of nose, swollen upper lip, and bilateral knee bruising with pain noted. Bleeding was controlled, vitals were BP(blood pressure)[TRUNC