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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**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:<br><br>R3<br><br>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).<br><br>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.<br><br>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) .<br><br>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.<br><br>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.<br><br>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<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | floor was wet/slippery at the time of the fall.<br><br>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 .<br><br>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].<br><br>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.<br><br>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.<br><br>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 .<br><br>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.<br><br>Review of R3's care plan revealed that nonskid strips were not added to the care plan as an intervention.<br><br>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.<br><br>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.<br><br>Several requests for further fall investigations including root cause analysis investigations for the reoccurring falls went unfilled.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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.<br><br>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 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Review of R106 Nurse Progress Note, dated 3/15/26 at 3:08 p.m., reflected, pt returned from ER.<br><br>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.<br><br>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.<br><br>Review of R106 Event Progress Note, dated 3/19/26 at 12:48 p.m., reflected, Investigation Summary<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 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.)<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | transfer.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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.<br><br>During an interview on 3/26/2026 at 3:43 PM, MDS C verified R106 was assessed to need two person 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.<br><br>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<br><br>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.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 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.<br><br>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.<br><br>Resident #17 (R17)<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #71 (R71)<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Resident #98 (R98)<br><br>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.<br><br>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.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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. 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.<br><br>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 |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on interview and record review, the facility failed to develop and maintain a Quality Assistance and Process Improvement (QAPI) program which identified and prioritized quality deficiencies, systematically analyzed the underlying causes of systemic quality deficiencies, and implemented effective corrective action or performance improvement activities to remedy those deficiencies. This deficient practice has the potential to affect the safety and quality of life of all 93 residents at the facility.Findings Included: On 03/27/2026 at 01:01 p.m. an interview was conducted with Nursing Home Administrator (NHA) A regarding concerns identified during the current Recertification Survey. NHA A explained that during the last year the QAPI committee had identified areas of concerns as return to hospital, weight loss, falls, and dietary menus. NHA A was asked how QAPI projects were identified. NHA A explained that items are identified through communication with staff, through the grievance project, and resident council. NHA A explained that any staff or resident may bring items to the QAPI committee. NHA A was asked how areas of concern were determined to need a QAPI project to resolve the identified concern. NHA A explained that the QAPI council would make that determination. NHA A was asked how items are tracked and trended on a regular basis to ensure quality of care of care to residents. NHA A could not provide answers to how systems or items are monitored on a regular basis or tracked and trend for compliance with quality of care. NHA A was provide with information with regarding to the odor on A hall. When asked if the issue had been monitored, tracked, and/or trended as a QAPI project she explained that the facility had been working and attempting to address the issue but could not provide any documentation. When asked again if it had been identified as QAPI project, NHA A explained that it had not been a project but she explained that it should have been. When asked if any issues had been identified during QAPI that had also been identified during the annual recertification survey, NHA A could only list falls and dietary menus. Review of facility policy entitled Quality Assessment & Assurance Program, adopted 07/11/208 and last revised 09/18/2019, revealed section entitled Data Collection which stated The QAA coordinator reviews information since the last QAA meeting with QA subcommittee(s) members, QAPI Action Plan Teams and QAA Committee members in order to formulate an agenda. The same policy listed Facility Trends: Admissions, Transfers, DischargesCustomer Service IssuesResident/Family Satisfaction SurveysResident RightsQuality of CarePressure ulcersPainRestraintsFalls,IncontinenceActivities of Daily Living(ADL) declineNosocomial infectionsWeight lossPsychoactive MedicationsMedication Management/Significant Medication ErrorsBowel/Bladder Function, CathetersUnexpected Hospital ReadmissionsSufficient StaffingStaff CompetencyThe same policy listed Additional DataIncident/Accident ReportsRisk Reports, Trigger Events, Occurrence Investigations Abuse Prevention/Allegation of AbuseConcern Forms/GrievancesDaily Meeting Care Line CallsNursing ServicesClinical GuidelinesQA/QIS Tools completed by Facility staffEmergency ManagementThe same policy listed ReportsSafety Committee MeetingEmployee Safety/Workplace SafetyOSHA LogResident Safety/Environmental SafetyEquipment SafeyLife Safety Code ComplianceFire SafetyEmergency PreparednessMedical Director's ReportRequested Consultant ReportsQuality of Life (QOL) OutcomesOpen Survey Timelines/F TagsCasper Reports5-Star RatingsSurvey Readiness VisitsThe same policy revealed section Leadership Oversight stated: Quality Assurance and Performance Improvement is facilitated through leadership oversight. This is achieved through structured and ad hoc committee meetings daily, monthly, and quarterly. The focus of a QAA meeting is to identify system to better meet the needs of residents, organize interdisciplinary teams, clarify the knowledge of the situation, understand the cause of variation within a system, select improvement strategies and monitor outcomes. |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on interview and record review, the facility failed to adequately address and make good faith effort to resolve grievances for 7 of 7 Resident Council members. Finding incleude:Review of Resident Council meeting minutes dated 9/30/25 the council members complained in part, they were not receiving certain menu items and had concerns regarding the quality of the food. The response signed off by Nursing Home Administrator (NHA) A was to print menus ahead of time. There was no response provided the concern related to the quality of food being served. The Resident council meeting minutes 10/27/25 reflected the quality of food was bad and food was cold and some meals were being served late and menu items that were requested were not provided. The grievance/resolution form dated 10/28/25 that was signed off by NHA A revealed residents should talk with the Dietary manager if they have an issue and Dietary Manager will check with residents randomly to see if there are any issues. Review of Resident Council meeting minutes dated 12/30/25 revealed complaints that residents were not receiving items requested from menu. The response signed off by NHA A dated 1/05/26 was that the Dietary manger will audit requested items and Dietary manager will randomly check with residents and if residents have an issue, they should tell Dietary manager at that time, not wait for Resident council. Review of Resident Council meetings dated 1/30/26 revealed concerns that dietary staff were not following meal tickets and not receiving items requested from the menu. The response on the concern form signed off by NHA A on 2/05/26 was to let the Dietary manager know when this occurs, random questionnaires to be done and to remind staff about menus. Review of Resident Council meeting minutes dated 2/27/26 reflected concerns related to cold food, accuracy of the meal trays, not being given menus. The response signed off by NHA A dated 3/4/26 was random audits, test trays and reeducating staff on passing trays timely, educating dietary staff on reading meal tickets to ensure resident preferences are honored. During the Resident Council meeting held on 3/25/26 7 out 7 resident council participants reported month after month they complain food quality, temperatures, not being provided menus, not receiving items requested, receiving items they dislike etc . 7 of 7 participants stated it's the same complaints over and over falling on deaf ears and never getting resolutions. On 3/26/26 at 11:28 am during an interview with Dietary Manager Y she reported being aware of concerns brought forth by Resident council and was trying to address them. A request for the audits as described in the concern forms response was requested. Dietary manager Y provided audits with food temperatures, several pages of undated food temperatures, there were no audits that pertained to accuracy of meal trays/honoring food preferences and menu concerns. Dietary manager Y stated they use a buddy system to ensure menu were provided and received back to the kitchen along with tray accuracy to ensure resident preferences are met, however there was no documentation this was done. When quired why/how this was a constant concern brought up monthly by Resident Council, Dietary Manager Y stated food temperatures were within range when leaving the kitchen. During an interview with NHA A on 03/26/2026 at 12:28 PM, NHA A stated she does not attend Resident Council and could not speak on the matter but did confirm she was the person who signed off every month on the concern forms. When queried if she found it concerning the same topic is brought forth month after month and being signed off by NHA A, NHA A offered no response. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on interview and record review the facility failed to ensure that 7 of 7 of the Resident Council members were informed of their right on how to file a grievance with the facility.Findings include:On 3/25/26 at 10:00 during the Resident Council meeting, 7 of 7 of the participants reported they collectively had chronic complaints about food palatability, menu items, food preferences not being honored, and noise levels. Individual participants then voiced individual concerns (late medications, call lights response times etc ) when queried if they had voiced their concerns or filed a grievance/concern form. None of the seven participants knew that was an option or how/where the forms were located. One of the Resident Council participants stated they thought they had to attend resident council in order to get their grievance/concern documented. Review of Resident Council minutes from September 2025 through February 2026 did not reflect resident rights were reviewed in their meetings pertaining to the facility grievance policy. On 03/27/2026 at 9:51 AM, during an interview Activity Director BB she reported she conducted Resident Council meetings monthly and stated she thought she had mentioned it in previous meetings. Documentation over the last year that grievances, the facility policy and or resident rights related to filing grievances was reviewed since the last certification survey was requested. No documentation was provided by the exit of the survey on 3/27/26. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>Based on interview and record review the facility failed to ensure 7 of 7 of the resident council members food preferences were met on a daily basis. Findings include:Review of the Resident Council meeting minutes dated 9/30/25, 10/27/25, 12/30/25, 1/30/26 and 2/27/26 reflected concerns that Resident Council members complained that food preferences were not being honored. During the Resident Council meeting held with the State Agency on 3/25/26 7 of 7 participants stated this had been a long standing issue that was not being addressed. Resident Council members reported being frustrated and angry that basic food and drink preferences were not honored. Example was given wanting orange juice every day at breakfast but receiving apple juice instead. On 3/26/26 at 11:28 am during an interview with Dietary Manager Y she reported there were no audits that pertained to accuracy of meal trays/honoring food preferences and menu concerns. Dietary manager Y stated they use a buddy system to ensure tray accuracy and resident preferences were met. When quired about the effectiveness of the buddy system for meal tray accuracy Dietary Manager Y did not respond. When asked the root cause of the ongoing issue Dietary Manager Y declined to answer. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure accurate advance directive (legal documents that allow a person to identify decisions about end-of-life care ahead of time) information was in place for one resident (#100) of two resident reviewed for advance directives.Findings include:<br>Review of the clinical record revealed Resident 100 (R100) was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure and congestive heart failure.<br>Review of the Minimum Data Set (MDS) with an assessment reference date of 3/25/26 revealed R100 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status. Review of the nursing progress notes dated 3/19/26 reflected R100 was alert and oriented x 4, was able to make needs known and had a diagnosis of respiratory failure with several comorbidities. The progress notes also reflected R100 made it known he did not want to be resuscitated in the event his heart stopped. Do Not Resuscitate (DNR). Further review of the clinical record reflected R100 and the facility Physician signed the Advanced Directive document on 3/19/2026 reflecting R100's wish to be a DNR. Review of Physician orders on March 25, 2026, reflected R100 was a full code. On 03/25/2026 at 7:46 AM, during an Interview with Licensed Practical Nurse (LPN) G stated in event of a code the first place to verify the code status would be the Medication Administration Record (MAR). R100's MAR was viewed with LPN G which reflected R100 was a full code. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Through interview and observations, the facility failed to maintain a homelike environment without the overpowering smell of urine for two residents (R7 and R11) of two residents reviewed for a homelike environment with the potential to affect all residents on that hall. Findings IncludeResident #11 (R11)Review of the medical record reflected that R11 was admitted to the facility on [DATE]. Diagnoses of paraplegia, acute kidney failure, encounter for fitting and adjustment of urinary device, abnormal gait and mobility.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/11/2026 revealed R11 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 R11 was maximal assistance on toileting, showering, dressing lower body, sit to stand and transferring from one surface to another. 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. During the screening process on 03/24/2026 at 10:19 AM, R11 stated he had a few UTI's, with an overpowering smell of urine from this room. Writer observed R11 draining his foley catheter urine in a urinal, then sitting it on bedside table, R11 had a hand towel lying on his lap due to it spilling urine transferring it from the foley catheter to the urinal. R11 stated his hand towel got wet with urine and he let it dry over his lap. During this same screening process on 03/24/2026 at 10:19 AM, R11 had a room mate R7, who shared the room with the overpowering smell of urine.During an observation and interview on 03/23/2026 at 2:30 PM, R11 had the same soiled hand towel lying on his lap that he had used earlier today. An overpowering smell of urine can be detected by a few rooms down the hallway before reaching R11's room.During an interview on 03/25/2026 at 12:56 PM, LPN G and CNA CC stated housekeeping comes in and cleans R11's room, but R11 doesn't want the foley connected to the collection bag during the day, he prefers to drain it himself into the urinal. CNA CC stated when he disconnected the tubing from the bag, R11 spills urine on the floor, even when it was cleaned up, the smell of urine lingers. LPN G and CNA CC stated he had a towel he laid across his lap to catch the urine. CNA CC also stated when he drains the foley catheter, he kept the same hand towel and continued to use it. CNA CC also stated the urine was probable soaked in the flooring. Writer asked if roommate R7 was able to report the smell of urine to them, CNA CC stated no, he isn't not able to tell them. Writer asked CNA CC if R7 had visitors that had to spend time in that room. CNA CC stated the hospice staff come several times a week but was unsure about other visitors.During an interview on 03/25/2026 at 2:09 PM, housekeeper DD stated she cleaned his room every day, sometimes two times a day. Housekeeper DD stated she changed out her mop head every time she cleaned his floors because it is so bad. Housekeeper DD added she moves the bed and his dresser to clean under it, mentioned it soaked into the flooring. Housekeeper DD stated R11 had urine all over the bed table legs and base are always covered with urine and smells so strong. Housekeeper DD stated Maintenance Director P was aware of this, and they are going to do a deep cleaning in the next week or two. During an interview on 03/25/2026 at 2:19 PM, Maintenance Director P stated they have bought R11 a new mattress three or four times a year. Maintenance Director P stated they could strip the floor and rewax it but getting him out of his room is difficult. Maintenance Director P added R11's dresser probably needed to be swapped out too if it is absorbing the urine. Maintenance Director P stated he<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was going to talk to NHA A to swap out his dresser for a plastic/PVC (poly vinyl chloride) structure, so it won't absorb the urine. During an interview on 03/26/2026 at10:04 AM, DON B stated she didn't know if it was in an Interdisciplinary Team Meeting (IDT), and morning meetings, that they were using charcoal bags in R11's room due to the smell. DON B stated she was unsure what to do next. DON B stated the management team talked about it yesterday, replacing nightstand/dresser. DON B stated even after R11 shower, it still smells really strong, in his skin and in the room. Writer asked if roommate, R7 was able to complain about the smell, DON B stated no. Writer asked DON B if R7 had visitors that had to spend time in that room. DON B stated not sure. DON B stated they had heard issues with other residents that it was offensive to them and they were trying to find a solution.<br>Writer asked DON B if they had talked to R11 about this concern. DON B stated R11 is non-complaint with receiving care, allowing staff to help with emptying his foley catheter. Regarding the resident's care plan, DON B stated all it said was to assist him, she was going to add something about him being non-compliant. DON B observed looking for nursing notes regarding non-compliance, nothing so far. Writer asked DON B what she would put in the care plan, and DON B asked writer what she should write on it. During an observation and interview on 03/26/2026 at 3:33 PM, CNA EE replaced the soiled towel on R11's lap that he had used to drain his foley catheter urine into a urinal that is currently on his over the bed table.During an observation and interview on 03/26/2026 at 3:38 PM, R7 was resting on his bed with his eyes closed. R7 had a BIMBS of 10 and was not able to speak for himself regarding the overpowering smell in his room. Using the reasonable person standard, R7 would be affected by this overpowering smell of urine in his homelike environment. |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a significant change Minimum Data Set was completed timely in one (Resident 3) out of 19 reviewed for Significant Change Minimum Date Sets. Findings include. 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 . 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<br>(continued on next page) |

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| | 235504 | A. Building<br>B. Wing | 03/27/2026 |

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| Springcreek Rehabilitation and Nursing Center | 130 Sand Creek Highway<br>Adrian, MI 49221 |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 confirmed 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 R3's significant change MDS revealed a completed date of 2/23/26. In an interview on 03/27/2026 at 10:40 AM, MDS Licensed Practical Nurse (LPN) C stated that significant change MDS's are to be completed 14 days after the change occurs that requires a significant change MDS. MDS LPN C confirmed that R3 required a significant change MDSfor his hip fracture and decline in ADL function, however, confirmed it was completed past the 14 days. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to revise care plans for three residents (R1, R4 and R7) to reflect a room change, use of hand rolls and receiving hospice services of 19 residents reviewed. Findings IncludeResident #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 mention she wanted the hair shaved on her chin. CNA Z stated that she would take care of that. Record review showed that R1 had not had a shower or bed bath in the last 30 days. Nor had 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 had 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 if staff had noticed R1 was not getting her showers? DON B stated apparently not.During an interview and observation on 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. 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<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 contained 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 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 care.Writer requested R7s shower sheets on 03/25/26 at 4:42pm. The shower sheets were requested again 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. 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<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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. 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.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 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<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**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 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<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 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<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 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<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review this facility failed to maintain range of motion in one resident (R#4) of two residents reviewed for range of motion resulting in failure to participate in her activities of daily living.Findings IncludeResident #4 (R4)Review of the medical record reflected that R4 was admitted to the facility on [DATE]. Diagnoses of chronic obstructive pulmonary disease, urinary tract infection, dysphagia (difficulty swallowing) chronic respiratory failure, pressure ulcer of sacral region- stage 3, paraplegia- incomplete, chronic pain, muscle wasting and atrophy.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) revealed R4 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 R4 was dependent for showers, personal care, toileting, dressing lower body, sit to stand and transferring from one surface to another.During an interview on 03/24/2026 at 9:54 AM, R4 stated they don't do any Range of Motion (ROM) on her left side because her bed is up against the wall. R4 stated she was able to move her arms back and forth when she got to this facility, as her discharging hospital really worked with her in their inpatient therapy department. R4 also stated she could move her wrist, hand and fingers freely. R4 stated she still needed help with most things, but she had some mobility. R4 stated when the CNAs came in to change her brief, they would pull the head of the bed towards the middle of the room so each CNA could be on both sides of her. Writer asked R4 if they provided ROM when they got her dressed. R4 stated heck no! They haven't done it at all; R4 stated she doesn't get dressed so they don't do anything but change her brief. Writer asked R4 how often the staff come in to reposition her. R4 stated once a shift if that, added during the night, she may get her brief changed once, but they don't do anything but change her brief and left the room.Record review revealed R4 was care planned to be checked and changed every two hours and as needed. R4 was dependent of one staff to repositioning and turning in bed. R4 was dependent on two staff and use of a mechanical lift to transfer from one surface to another. R4 was care planned for staff to follow the plan of care to assist R4 in maintaining optimal level of strength, function and medical status. R4 was care planned for pain management, staff to evaluate the effectiveness of pain interventions, review for alleviating of symptoms, dosing schedule and resident's satisfaction with results, impact on functional ability and impact on cognition. R4 needed head of the bed elevated as needed for comfort and support respiratory function. Position R4 with proper body alignment for optimal breathing pattern. Elevate heels off the mattress/bed while at rest in bed as tolerated. Follow physician orders for treatment of skin impairments. Provide pain management with treatments as needed. Monitor/document location, size and treatment of skin injury, report abnormalities to the physician. Turn and reposition R4 every two hours and as needed as R4 tolerates, encourage R4 not to lay directly on her buttock for pressure relief.Record review also revealed R4 was rolled from left to right side, two to three times a day during the last 30 days according to the task sheet filled out by CNAs caring for her, not every two hours as care planned. R4 was not repositioned every two hours during the last 30 days according to the task sheet filled out by the CNAs caring for her. According to the Medication Administration Record (MAR) R4 received her Oxycodone HCl 5 mg capsule every 8 hours (0000, 0800,1600) and rated her pain #3 to #10 on a scale of 0-10, including the prn/as needed dose allowed once daily. R4 reported a pain level of #2 to #6 on a scale of 0-10 during wound care to her coccyx pressure ulcer, stage 3. Wound care orders to be done at 7:00AM, included cleanse the coccyx pressure ulcer with normal saline, pat dry, mix Triad paste and medi-honey together and apply to wound bed, leave open to air. R4 had Oxycodone HCl 5mg capsule scheduled at 0800, after the wound care for R4's pressure ulcers, not before the wound care for increased pain during treatment. During an interview on 03/26/2026 at 8:01 AM, Regional Physical Therapist II, stated he was filling in at this facility. Writer asked him about the condition of R4 when<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | she got here. Regional Physical Therapist II, stated R4 was pretty much dependent on everything, bed mobility, mechanical lift, etc. Writer asked Regional Physical Therapist II about the Occupational Therapy (OT) evaluation on admission stated R4 was within functional limits. Regional Physical Therapist II, stated R4 had some elbow and wrist movement. Regional Physical Therapist II, then stated the OT evaluation cannot be right, because R4 isn't able to do anything. Regional Physical Therapist II stated he evaluated her repositioning in her bed, and she could not do it. Regional Physical Therapist II, questioned the OT evaluation. Writer asked about a restorative program, he didn't know if they had an actual program but stated the CNAs are to do some ROM with care. Regional Physical Therapist II, stated it would be best to speak to nursing about a restorative program, as Regional PT, he didn't know if they had a restorative program. During an interview on 03/26/2026 at 8:11 AM, Occupational Therapist (OT) JJ stated R4 had rolled wash cloths in the palms of her hand as tolerated to prevent further restriction of movement and prevent fingernails form going into her palms, adding she had educated the family/husband. During an interview on 03/26/2026 at 8:19 AM, unit manager/LPN E stated they did not have a restorative program, no, it is expected that the CNAs provide ROM with morning care and night care. Writer asked about R4 not getting dressed daily, she wears a hospital gown, so not getting ROM with getting dressed activities. Writer also noted R4 does not wear footwear. Unit manager/LPN E stated it is still the expectation.During an interview on 03/26/2026 at 10:39 AM, DON B stated it was incorporated into R4s ADLs, but there was very little she would let you do with her. DON B stated she was on routine pain medications and anxiety medications. DON B stated R4 came into the facility with prn/as needed anxiety medication of Xanax 0.5mg every 8 hours as needed, ended on 03/09/26, then on 03/10/26 new script for Xanax 0.5 mg bid. admitted with Oxycodone 5 mg every 6 hours as needed, changed on 03/10/26 to Oxycodone 5mg bid, then on 03/11/26 changed it to Oxycodone every 8 hours, added a prn dose. DON B stated R4 had a lot of chronic pain.Writer asked DON B about R4s ROM and wash clothes rolled up and placed in her hands to prevent further restriction of movement. DON B observed looking for it on R4's care plan. DON B stated she couldn't find it, was not added to the care plan. Writer asked what ROM was done if R4 wears a hospital gown and doesn't get dressed or wear footwear. DON B stated she didn't know. Writer asked if there was any documentation to support that R4 received ROM. DON B stated it was the expectation that staff provide ROM to residents, so no not specifically.Record review revealed R4 was admitted to facility and the OT evaluation and plan of care documented R4 had upper body range of movement within functional limits.During an interview on 03/26/2026 at 3:39 PM, CNA KK stated R4 would let them move her legs a little and maybe her arms due to her pain level, everything hurts R4. CNA KK stated R4 did not like having the head of the bed down at all because it was hard for her to breathe. During an observation and interview R4 did not have any movement or mobility in her arms, wrist, hands or fingers at the time of discharge from this facility on 03/25/2026 to another facility. R4 could be seen grimacing and calling out due to pain with movement of extremities, rolling to provide brief change and peri-care, completion of the wound care to her pressure ulcer, stage 3 on her coccyx. R4 stated many times that her pain was not maintained at a tolerable level. R4 was not wearing any washcloths rolled up in her palms. R4 also stated that she had lost the mobility she had on admission to this facility. R4 stated her pain was not managed, they knew the extent of her pain and did not offer pain medications prior to wound care, or the few times they did reposition her. R4 stated they did not use the rolled wash clothes in her palms to prevent further restriction of movement, because they didn't put it on the care plan after being ordered by occupational therapy. R4 was tearful and stated she was glad to be transferring to another facility because they did nothing for her here. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure respiratory care, including tracheal suctioning was provided consistent with professional standard of practice for one Residents (#6) of three Residents reviewed for respiratory care. Findings Included:Resident #6 (R6)Review of the medical record revealed R6 was admitted [DATE] with diagnoses that include dysphagia (difficulty swallowing), cerebral infarction (stroke), tracheostomy (a surgical opening in the trachea), gastrostomy (a feeding tube inserted through the abdomen directly into the stomach to provide nutrition), chronic respiratory failure, pressure injury to right heel, anxiety, insomnia, abnormal posture, lack of coordination, language deficits, paralysis right side of body, type 2 diabetes, hypertension, gastro-esophageal reflux, and protein-calorie malnutrition. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/2023, revealed R6 had a Brief Interview of Mental Status (BIMS) that could not be assessed because the resident is rarely/never understood. During observation and attempted interview on 03/24/2026 at 01:24 p.m. R6 was observed lying down in bed. R6 did not respond to verbal stimuli. R6 was observed during this time to have a tracheostomy tube connected with tracheostomy ties. The tracheostomy ties appeared to be soiled with dried on mucus. A oxygen compressor was observed connected to an oxygen circuit of tubing with humidification that was connected to the oxygen collar and observed to be placed over R6's tracheostomy tube opening. The oxygen collar and oxygen circuit tubing was not observed to have been dated. Oxygen tubing was observed connected to a oxygen concentrator and the oxygen circuit. The oxygen tubing was not observed to be dated. Review of R6's treatment administration record (TAR) revealed an order Change all trach (tracheostomy) tubing, mask, and suction canister every night shift every Sun (Sunday) for reducing risk and change trach ties every night shift every Sun for management & infection risk reduction. Review of R6's March TAR revealed 03/22/2026 was blank for the treatments change all trach (tracheostomy) tubing, mask, and suction canister every night shift every Sun (Sunday) for reducing risk and change trach ties every night shift every Sun for management & infection risk reduction.On 03/25/2026 at 09:05 a.m. R6 was observed sitting up in a geriatric reclining wheelchair. At that time Licensed Practical Nurse (LPN) Q explained that she was going to suction R'6 and change the inner cannula of his tracheostomy. LPN Q was observed to place an isolation gown on. LPN Q was observed to open a suction kit which included sterile gloves and the suction catheter. LPN Q was then observed to place sterile gloves on both hands and proceed to connect the unsterile suction tubing (held with left hand) and connect it to the sterile suction catheter (held with the right hand). LPN Q was then observed to not have turned on the suction cannister. LPN Q explained that she needed to plug in the suction cannister. LPN Q was then observed to place her sterile gloved right hand (which was holding the sterile suction catheter) on the bed, with the suction catheter also touching the bed. Once the suction cannister was plugged in she was observed to suction R6's tracheostomy. LPN Q was observed to discard the suction catheter, remove her gloves, and then place non-sterile gloves on both of her hands. LPN Q was then observed to remove R6's inner tracheostomy cannula. LPN Q then was observed to perform outer tracheostomy care using sterile q tips and sterile saline. LPN Q was then observed to pick up a sterile inner tracheostomy cannula (without changing her gloves) from its container and place it in R6's outer tracheostomy cannula. LPN Q was then observed to change R6's tracheostomy ties without changing her gloves or washing her hands.On 03/25/2026 at 09:36 a.m. Director of Nursing (DON) B explained that suctioning of a tracheostomy was to be completed using sterile technique, which was facility policy and professional standards. DON B also explained that replacing the inner cannula of a tracheostomy was to be completed using sterile technique. Which was facility policy and professional standards. DON B explained that sterile technique was used to decrease the risk of infection to the Resident with a tracheostomy. DON B was asked to review R6's March Treatment Record (TAR). DON B confirmed<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that R6's March TAR did not demonstrate that R6's orders were completed on 03/22/26 as written to Change all trach (tracheostomy) tubing, mask, and suction canister every night shift every Sun (Sunday) for reducing risk and change trach ties every night shift every Sun for management & infection risk reduction. DON B explained that he was discharge to the emergency room on that date so that is why R6's treatments on 03/22/2026 was not completed. DON B confirmed that the last charting that all tracheostomy tubing, mask, and suction canister had been changed for R6 was 03/15/2026. On 03/25/2026 at 09:48 a.m. Director of Nursing (DON) B was observed going to R6's room. DON B explained that the oxygen tubing and the humidification tracheostomy circuit should be dated for the last time it was changed. DON B confirmed that no dates were present on the oxygen tubing and the tracheostomy humidification circuit. Review of facility policy entitled Tracheostomy, Suctioning of, adopted 07/11/2028 and last updated 04/01/2024, revealed the following procedure: . 4. Wash hands, set up equipment and put on personal protective equipment. 7. Open sterile packages and prepare irrigation and rinsing solutions, maintaining sterility.8. Put on sterile gloves in order to handle catheter. A sterile hand is maintained for the catheter, and a non-sterile hand is used to regulate the suction. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>Based on observation and interview the facility failed to remove all expired medications from two of four medication administration carts used to administer medications to residents with the potential to affect half of the facility census of 93. Findings Include During observation and interview on 03/25/2026 at 8:16 AM, writer asked to look through medication cart labeled Hall A. Writer found Allergy Relief 24 hr. 180mg tab expired 01/26. Naproxen Sodium 220mg tab expiration date has been removed, all white with no date.During observation and interview on 03/25/2026 at 8:36 AM, writer asked to look through medication cart labeled Hall B. Writer found Cetirizine HCl 10 mg tab- Expiration date had been removed, wiped off, plain white area where expiration date was.During observation and interview on 03/25/2026 at 10:45 AM, writer asked to look through the medication room at the nurses' station. No outdated medications found, refrigerators and freezer temperatures were present and within normal range.During an interview on 03/26/2026 at10:29 AM, DON B stated it would be the expectation that all nurses look at the expiration dates on the bottles and dispose of them once they identify they are expired. |

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| | 235504 | A. Building<br>B. Wing | 03/27/2026 |

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

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, interview, and record review, the facility failed to ensure the published menu was served as planned to six residents and residents were consistently informed in advance of any menu changes affecting all residents consuming food from the kitchen resulting in resident dissatisfaction with their meal experience and feelings of frustration related to meals voiced in confidential resident group the the potential to effect all 93 residents. Findings include:During an observation and interview on 3/24/2026 at 9:19 AM, tour of kitchen with Kitchen Manager (KM) Y. Menus were reviewed and KM Y reported residents had option related to menus and reported if residents did not prefer main dish they had option for alternative option and also had options for always available items. During an observation, interview and record review on 3/25/2026 at 11:15am, this surveyor observed tray line services. KM Y and cook verified posted menu that included roast beef, potatoes, butter carrots, roll, and beverages. Observed several resident meal tickets with request for grilled cheese and veggie burgers honored. Observed entire try line that started with Hall C, followed by Hall D, Main Dinning Room, Hall B, and finished with Hall A. Observed six resident meal tickets that had requested main menu remaining during Hall A service that were served burgers after running out of posted main menu item roast beef. During an interview at 12:10 p.m., KM Y confirmed they had run out of roast beef for six residents who had ordered roast beef and alternative protein of burgers were placed in oven to serve to those residents. During an interview on 3/26/26 at 6:50pm, Nursing Home Administrator (NHA) A reported would expect meals to be served to residents as posted and according to resident preference including main menu items. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure palatable and appetizing food was served to two (Resident #2 and Resident #49) of 2 residents reviewed for receiving palatable and appetizing food, resulting in potential for decreased oral intake.Findings include:During an observation on 3/25/2026 7:21 AM, this surveyor observed a full uninsulated tray cart located on Hall C (secure memory unit) with no staff delivering trays at that time. Two nurses were observed at medication cart and several residents were observed wandering the hall and six residents were sitting at the dining room table at the end of the hall with no staff in the dark. Continued observation on 3/25/2026 at 8:08 AM, Certified Nurse Aid (CNA) LL entered R2 room with breakfast tray. (about 45 min after arrival of tray) Continued to observe and at 8:15 AM R49 was served first bite of breakfast with staff assist. (almost one hour after tray delivered). Observed 11 residents in secure memory dining room with two staff in dining room. Staff assist two other residents at Dining room table. Observed staff attempting to cut toast and unable to be cut after attempt and observed staff breaking up oatmeal that had [NAME] solid top layer and staff stirred for resident on her right side. During an interview on 3/25/2026 at 1050 am CNA LL and CNA MM reported resident on her right-side during morning meal did not eat well this morning and verified was unable to cut toast. During an interview on 3/26/2026 at 6:50 pm, Nursing Home Administrator (NHA) A reported would expect meal trays to delivered to residents immediately after arrival. |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>Based on observation, interview, and record review the facility Arbitration Agreement failed to explicitly state that neither the resident nor his or her representative was required to sign an agreement for binding arbitration as a condition of admission, or as a requirement to continue to receive care at the facility and state that the binding arbitration agreement allows the resident or anyone else to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health departement employees and representatives of the Office of the State Long Term Care Ombudsman for one resident (#73) of three Resident reviewed for Arbitration Agreements. Findings Included:Resident #73 (R73) Review of the medical record revealed R73 was admitted to the facility 02/01/2023 with diagnoses that include atherosclerotic heart disease (plaque build-up in artery walls), polyneuropathy (wide spread peripheral nerve damage), insomnia, contracture (long lasting tightening of muscle) of left elbow, lack of coordination, muscle weakness, dementia, abnormal posture, chronic obstructive pulmonary disease (COPD), dysphagia (difficulty swallowing), hypertension, cognitive communication deficit, alcohol abuse, gastro-esophageal reflux, and chronic hepatitis (inflammation of the liver). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2026, revealed R73 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During an interview on 03/26/2026 at 10:49 a.m. R73 was observed lying in bed. R73 explained the purpose of the facility arbitration agreement but was not willing to review the actual Resident Arbitration Agreement that was signed on 02/03/2023 or the Resident Arbitration Agreement that was signed on 03/25/2026. R73 could not explain why the Resident Arbitration Agreement was resigned by him on 03/25/2026.Review of the facility Resident Arbitration Agreement signed by R73 on 02/03/2023 did not explicitly state that neither the resident nor his or her representative was required to sign an agreement for binding arbitration as a condition of admission, or as a requirement to continue to receive care at the facility. The same Resident Arbitration Agreement signed by R73 on 02/03/2023 did not state that the binding arbitration agreement allows the resident or anyone else to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health departement employees and representatives of the Office of the State Long Term Care Ombudsman. During an interview on 03/26/2026 at 11:48 a.m. admission Director (AD) N explained that Residents are offered to enter into a Resident Arbitration Agreement upon admission. AD N confirmed that the Resident Arbitration Agreement, signed 02/03/2023 by R73, did not explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission, or as a requirement to continue to receive care at the facility. AD N confirmed that the Resident Arbitration Agreement, signed 02/03/2023 by R73 did not state that the binding arbitration agreement allows the resident or anyone else to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health departement employees and representatives of the Office of the State Long Term Care Ombudsman. AD N explained that the facility identified that R73's Resident Arbitration Agreement did not meet the requirements when the facility was asked to provide R73's Resident Arbitration Agreement during the survey process. AD N explained that R73 was asked to sign a new Resident Arbitration Agreement on 03/26/2026, after the above was identified. |

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| F 0848<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide a neutral and fair arbitration process and agree to arbitrator and venue.<br><br>Based on observation, interview, and record review the facility Arbitration Agreement failed to explicitly state that the agreement provided for the selection of a neutral arbitrator agreed upon by both parties for one resident (#73) of three Resident reviewed for Arbitration Agreements. Findings Included:Resident #73 (R73)Review of the medical record revealed R73 was admitted to the facility 02/01/2023 with diagnoses that include atherosclerotic heart disease (plaque build-up in artery walls), polyneuropathy (wide spread peripheral nerve damage), insomnia, contracture (long lasting tightening of muscle) of left elbow, lack of coordination, muscle weakness, dementia, abnormal posture, chronic obstructive pulmonary disease (COPD), dysphagia (difficulty swallowing), hypertension, cognitive communication deficit, alcohol abuse, gastro-esophageal reflux, and chronic hepatitis (inflammation of the liver). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2026, revealed R73 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During an interview on 03/26/2026 at 10:49 a.m. R73 was observed lying in bed. R73 explained the purpose of the facility arbitration agreement but was not willing to review the actual Resident Arbitration Agreement that was signed on 02/03/2023 or the Resident Arbitration Agreement that was signed on 03/25/2026. R73 could not explain why the Resident Arbitration Agreement was resigned by him on 03/25/2026.Review of the facility Resident Arbitration Agreement signed by R73 on 02/03/2023, did not provide for the selection of a neutral arbitrator agreed upon by both parties.During an interview on 03/26/2026 at 11:48 a.m. admission Director (AD) N explained that Residents are offered to enter a Resident Arbitration Agreement upon admission. AD N confirmed that the Resident Arbitration Agreement, signed 02/03/2023 by R73 did not provide for the selection of a neutral arbitrator agreed upon by both parties. AD N explained that the facility identified that R73's Resident Arbitration Agreement had not meet the requirements when the facility was asked to provide R73's Resident Arbitration Agreement during the survey process. AD N explained that R73 was asked to sign a new Resident Arbitration Agreement on 03/26/2026, after the above was identified. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide coordination of care for hospice services for one resident (R7) of one reviewed for additional services above and beyond the facilities provides.Findings IncludeResident #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 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 care.Writer requested R7s shower sheets on 03/25/26 at 4:42pm. Having not received the shower<br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that appropriate hand hygiene was conducted during dressing changes for two residents (#63, #88) and during medication administration observation with the potential to affect facility census of 93. Findings included:During an observation on 03/25/2026 at 8:04 AM, LPN OO was preparing medications for R57, writer did not see LPN OO perform hand hygiene prior to getting in the medication cart. LPN OO did not perform hand hygiene before going into the R57's room nor after administering R57's medication. No hand hygiene in R57's room or prior to returning back to the medication cart.<br><br>During an interview with Infection Preventionist D stated she would expect the nurses to use hand hygiene between each resident. She did education on hygiene as well as an annual skills fair.<br><br>During an interview on 03/26/2026 at10:29 AM, DON B stated it would be the expectation that all nurses use hand hygiene between residents and after administration of medications.<br><br>During an observation on 3/25/2026 at 2:25 PM, Registered Nurse (RN) F reported was training RN J and planned to change R63 wound dressing. Observed RN J removed R63 soiled dressing from R63 right hip, wound was about baseball size diameter with rolled curled scared edges. RN J cleaned wound with normal saline, packed with fingers only with daken soaked gauze, covered with aquacell (not to wound bed), and ABD pad. RN J did not change gloves between soiled and clean dressing that required packing and did not follow treatment orders.<br><br>During an interview on 3/25/2026 2:42 PM, RN F reported would expect gloves change between dirty and clean dressing and verified walked away from dressing change for additional supplies and did not correct RN J and should have.<br><br>During an interview on 3/26/2026 at 1:28 pm, RN Infection Control D reported would expect nurse to follow provider order for treatments.<br><br>During an interview on 3/26/2026 at 6:50 pm RN D reported would expect nurses to change gloves between dirty and clean dressing changes.<br><br>Resident #88 (R88)<br><br>Review of the medical record revealed R88 was admitted [DATE] with diagnoses that include Fournier gangrene (flesh-eating bacteria affecting genital, perineal, or perianal regions), retroperitoneal abscess (collection of pus behind the abdominal cavity), muscle wasting, anemia (low red blood cell count), type 2 diabetes, hypertension, hepatic encephalopathy (decline in brain functioning related to sever liver disease), abnormal posture, and alcoholic cirrhosis (liver scaring). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/11/2026, revealed R88 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15.<br><br>On 03/24/2026 at 10:18 a.m. during observation and interview R88 was observed sitting up a recliner. R88 explained that he was receiving dressing changes to his scrotum. R88 also explained that he had a JP (Jackson Pratt) drain near the surgical site by his scrotum. R88 explained that staff performed dressing changes twice daily.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R88 medical record revealed current treatment orders, Cleanse JP (Jackson Pratt) drain site with wound cleanser, pat dry, skin prep around site and cover with split gauze around site on time per day. R88's medical record also revealed a current treatment order cleanse residents scrotum surgical site with normal saline, pat dry, wick plain packing strip into wound be then cover area with calcium alginate dressing and then cover with ABD pad, secure with tape every day and night shift for surgical incision.<br><br>On 03/25/2026 at 12:23 p.m. R88 was observed lying down in bed. R88 explained that he had removed his scrotal dressing so that Licensed Practical Nurse (LPN) O could perform the dressing to his surgical site and clean around his JP (Jackson Pratt) drain. LPN O was observed sanitizing hands, placed on gown, and then gloves. LPN O was then observed removing blood-soaked packing strips from R88's scrotum surgical site. Surgical site could not be viewed clearly as only present small hole with tunnelling. Observed LPN O cleanse the site with normal saline and packed with strips and removed. Skin prep was then applied, and site was packed with strips of calcium alginate and covered with dressing. R88 would not let nurse apply tap to dressing because he explained it irritated his skin. LPN O then went to closet and obtained a brief and assisted R88 applying brief. LPN O then removed her gloves and washed her hands.<br><br>During an interview on 02/25/2026 at 12:40 p.m. Director of Nursing (DON)B was asked to explain the process of performing a dressing change. DON B explained that it was her expectation that the following procedure be followed: hands are to be sanitized, the nurse would apply gloves and gown, the old dressing would be removed and discarded, the nurse would remove her soiled gloves, the nurse would wash or sanitize her hands, new gloves would be applied, if the dressing change included cleansing the wound the nurse would remove her gloves and wash her hands before proceeding with the clean dressing being applied, the new dressing would be applied, the nurse would remove her gloves, wash or sanitized hands and assist the resident with any further necessary assistance. DON B explained that gloves are to be changed and hand sanitized between the removal of a soiled dressing and the application of the new dressing to decrease the possibility of contamination of the new dressing.<br><br>Review of facility policy entitled Dressing, non-sterile, adopted 07/11/2018, revealed the following procedure .7. Wash hands, apply gloves, 8. Remove dressing and discard in plastic bag, 9. Remove gloves, wash hands, re-apply gloves, 10. Clean wound as ordered .11. Dispose of cleaning supplies in bag, 12. Remove gloves, wash hands, reapply gloves, . 14. Apply dressing as ordered, . 16. Remove gloves, 17. Assist resident to allowed position of comfort, ensure call light within reach, 18. Wash hands. |