STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235513	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Fulton	4735 Ranger Road Perrinton, MI 48871

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medication according to professional standards of practice for 1 resident (R2) of 12 residents reviewed. Findings include:Review of an admission Record revealed R2 admitted to the facility on [DATE] with pertinent diagnoses which included dementia, hypertension, anxiety, and history of falls. Review of R2's Physician's Orders revealed an active order for amlodipine besylate 10mg (a prescription medication used to treat high blood pressure), give 1 tablet my mouth one time a day, Hold if SBP (systolic blood pressure, the top number in a blood pressure reading, measuring the force in your arteries when your heart beats and pushes blood out) is less than 120, with a start date of 7/21/2025. Review of R2's Electronic Medical Record (EHR) on 12/18/2025 at 1:42 PM revealed nursing staff were not documenting blood pressure checks prior to administration of amlodipine since the medication start date of 7/21/2025. R2's amlodipine was documented on the Medication Administration Record (MAR) as administered at 0800 each morning, with no documentation in the EHR that the blood pressure was checked prior to ensure it was within the physician's ordered parameters. In an interview on 12/18/2025 at 2:49 PM, the Assistant Director of Nursing (ADON) N reported she reviewed the EHR and was unable to find documentation that nursing staff had completed any blood pressure checks prior to administrations of R2's amlodipine since the medication start date of 7/21/2025. ADON N reported the order was not placed into the EHR correctly. When placed correctly, the EHR prompts staff to check and document the blood pressure at the time of medication administration.

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

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide meaningful activities for 2 Residents (R2 and R6) of 12 residents sampled.Findings include:R2Review of R2's admission record dated, 12/18/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] he had diagnoses that included: wandering, vascular dementia and cognitive communication deficit. R2 was not his own responsible party.R2 was observed in bed on 12/17/25 at 8:32 AM awake in bed, breakfast tray on bedside table in front of him with all his food eaten.R2 was observed in bed on 12/17/25 at 9:23 AM with his breakfast tray in front of him. His eyes were closed, and he appeared to be sleeping.R2 was observed in bed on 12/17/25 at 9:34 AM. His walker was within eyesight but out of reach approximately 3 feet away from his bed. R2 was asked what activities he liked to do here, and he responded, I have not tried any yet.R2 was observed in bed again on 12/17/25 at 10:43 AM, he did not have a television, books or any meaningful activities visible in his room. He was still awake.Review of R2's Activity care plan dated 6/25/25 revealed, R2 enjoys a variety of activities but does not self-initiate leaving his room.he loves to chat; former bar owner and very involved in his community - able to independently choose what activities he wishes to participate in - would need reminders and encouragement - would need some assistance during r/t (related to) cognition. Interventions included: escort R2 to activities, invite and remind R2 of available and upcoming activities.Review of R2's electronic medical record reveals many activity tasks were listed. Some of the tasks listed included: women's club, busy hands, cooking club. R2's task documentation for women's club, busy hands and cooking club, was reviewed for the last 30 days and there was no indication that he attended any of these activities or any other activities.During an interview with the Activities Director (AD) W on 12/17/25 at 12:49 PM, AD W was asked about R2's activity preferences, and she said he does not like group activities. AD W stated R2 likes to sit and watch people by the nurse's station. AD W was asked how often R2 should be offered activities, and she said daily. AD W was asked for R2's records on what activities he was offered this month, and AD W ran a report on her computer that revealed 8 days this month he was not offered any activities, and no refusals were documented. AD W could not validate what activities R2 had participated in. AD W was asked for a copy of R2's activity attendance report. AD W was asked again for any documentation of R2 activity attendance on 12/18/25 at 9:00 AM. Upon exit the facility did not provide any documentation of R2's activities attendance.During an interview with Activity Aide (AA) X on 12/17/25 at 1:01PM, AA X said she works on Wednesdays and the weekends. AA X was asked about R2's activity preferences. AA X was not aware of R2's preferences and confirmed she had not assisted him with any activities this month.R6Review of R6's admission record dated 12/17/25 revealed she was admitted on [DATE] and had diagnoses that included spastic quadriplegic cerebral palsy, and developmental disorder of speech and language. It also revealed she was not her own responsible party.R6 was observed in bed in her room on 12/16/25 at 10:43 AM. The television was on cartoons with no audible sound. R6 did not answer any questions but looked at the Surveyor when she was speaking.R6 was observed in her room up in a wheelchair on 12/17/25 at 8:35 AM. She was connected to her tube feeding pump. She had cartoons on her television, but the volume was in a very low hardly auditable setting. R6 did not respond to any questions but did look at the Surveyor when she was asked questions.During an interview with Registered Nurse (RN) B on 12/17/25 at 9:20 AM in R6's room, RN B was asked if R6's television volume should be adjusted so R6 could hear the cartoons and RN B confirmed R6 liked cartoons and should have the volume adjusted. RN B was asked if R6 was assisted out of her room daily and RN B said when she was up in her wheelchair she should be assisted out of her room. RN B was asked how she could confirm staff were assisting her out of her room daily and she did not have any way to verify this was happening. The Surveyor expressed concern as R6 was left in her room this morning when she was out of bed and had now returned to her bed. The Surveyor had not (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed R6 out of her room at all on 12/17/25.Review of R6's care plan dated 8/18/25 revealed, R6 shows little awareness of programing surrounding. She would benefit from small group awareness and/or sensory stimulation r/t (related to) dx (diagnosis) of DD (developmental disorder), non-verbal -enjoys the company of favored staff and co-guests AEB (as evidenced by) smiling and blowing kisses -seems to enjoy watching tv (cartoons) and engaging with her manipulatives and stuffed animals - requires staff to anticipate what activities she would enjoy - requires staff to get her to and from - would benefit from mostly sensory activities.Review of R6's medical record revealed she had several activity tasks listed, they included gardening, games, happy hour, cooking club and arts and crafts. Review of R6's activities task documentation for gardening, games, happy hour, cooking club and arts and crafts was reviewed for the last 30 days and there was no indication that she attended any of these activities.During an interview with AD W on 12/17/25 at 1:08 PM, AD W was asked to verify that R6 was being offered daily activities. AD W ran a report for December 2025 and said R6 was missing activity documentation for 8 days this month. AD W could not say what activities were offered and had no explanation for the lack of daily documentation. AD W had no way to verify R6 was being assisted out of her room daily, or if anyone was assisting R6 with the television volume. The Surveyor requested a copy of R6 activity record for December 2025. On 12/18/25 at 9:00 AM a second request for R6 activity records was made and upon exit the facility did not provide any activities records for R6.During an interview with AD W on 12/17/25 at 2:46 PM, the Surveyor asked about R2 and R6's tasks in the electronic medical records that indicated they should be offered activities like busy hands, cooking club and several other things that did not seem appropriate for residents on tube feeding, men going to a woman's group, and residents who lacked movement in all 4 extremities going to a busy hands group. AD W said all residents on admission are given these canned tasks and she has not had time to remove the ones that are not appropriate. She was still not able to provide any documentation of which activities had been offered to R2 and R6 or evidence of any attendance to any activity.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the responsible party of the initiation of a psychotropic medication for one cognitively impaired Resident (R3) of six residents reviewed for psychotropic medications.Findings include:R3 was admitted to the facility 8/1/25 with pertinent diagnoses that included Dementia and Alzheimer's Disease. Review of the Minimum Data Set (MDS) dated [DATE] reflected R3 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated the Resident was severely cognitively impaired. The medical record reflected the spouse of R3 was the designated responsible party.Review of the Electronic Medical Record (EMR) Doctor's Orders reflected on 8/12/25 a telephone order for Lorazepam (Ativan), (a benzodiazepine anxiolytic (antianxiety) medication) 0.5 milligram (mg) to be administered every 4 hours as needed for anxiety/agitation.The EMR for R3 revealed the document titled Psychotropic Medication Informed Consent dated 9/10/25 and was reviewed. The document reflected the Guardian for R3 had been informed of the risks and benefits and given consent for the administration Lorazepam on 9/10/25 after the initial Doctor's Order dated 8/12/25. On 12/17/25 at 3:52 PM an interview was conducted with the Director of Nursing (DON). The DON acknowledged that the responsible party for R3 had not given informed consent for the initiation of Lorazepam. The policy provided by the facility titled Psychoactive Medication Management, last revised 9/7/25 was reviewed. The policy reflected Procedure.4. Residents receiving psychoactive medications upon admission, those with new psychoactive medications orders or an increase in the dose of the medication, will have a psychotropic medication informed consent completed. Before initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for the antipsychotic medications in advance of such initiation or increase.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to timely inform the party responsible of a fall sustained by a cognitively impaired (R3) of five residents reviewed for accidents.Findings include:Resident (R3) was admitted to the facility 8/1/25 with diagnoses that included Dementia and Alzheimer's Disease and was severely cognitively impaired. The medical record reflected the spouse of R3 was the designated responsible party and emergency contact.On 12/16/25 at 2:27 PM a telephone interview was conducted with the spouse of R3. The spouse reported that several months prior his wife had fallen, and he was not contacted for several days following the incident. The spouse reported he was upset that he had not been contacted and complained to the facility.Review of the incident report provided by the facility dated 8/16/25 at 2:15 AM reflected R3 had sustained a fall. The document reflected the responsible party was not contacted until 8/18/25 at 6:21 PM.The policy provided by the facility titled Fall Management last revised 7/8/25 was reviewed. The policy reflected Practice Guidelines: .6. The licensed nurse will notify the attending physician and the responsible party of the fall, and document the notification in the medical record.Review of the Electronic Medical Record (EMR) Progress Notes reflected an entry on 8/16/25 at 3:46 AM that R3 had been found on the floor. The Progress Note reflected the medical provider had been notified but not the responsible party. Review of later Progress Notes did not reveal the responsible party for R3 had been notified of the fall on 8/16/25.On 12/17/25 at 3:52 PM an interview was conducted with the Director of Nursing (DON). The DON reported that if a resident was not their own person the responsible party would be contacted if a fall occurred. The DON reported that if the fall occurred during the night and there was no injury the responsible party would be notified at a reasonable time. The DON acknowledged the responsible party for R3 should have been notified sooner of the fall sustained by R3.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their abuse policy and have a policy for reporting and investigating abuse for 2 Residents (Resident #2 and #24) out of 12 sampled residents.Findings included: Review of the facility Abuse Prohibition Policy last revised 9/9/22 revealed, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraint imposed for purposes of discipline or convenience that are not required to treat the guest's/resident's medical symptoms. To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guests/residents care and treatments on an ongoing basis. It is the responsibility of all staff to provide a safe environment for the guests/residents. Allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator, and report to the appropriate state agencies, physician, families, and/or representative. The subject of abuse should be routinely and openly discussed. Guests/residents will be educated concerning the commitment of the facility to deal quickly and effectively with abuse or suspected abuse incidents on admission and at least annually thereafter.Further review of the facility Abuse Prohibition Policy revealed there were no examples of abuse allegations, no information on who to report abuse to, and no information on the reporting process to the State Agency.R2Review of R2's admission record dated, 12/18/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: wandering, vascular dementia, and cognitive communication deficit. R2 was not his own responsible party.Review of R2's care plan dated 8/18/25 revealed, wandering/exit seeking: (R2) is at risk for exit seeking/wandering r/t (related to) dx (diagnosis) of dx TIA (stroke), cognitive communication deficit, UTI (urinary tract infection) hearing loss, adjustment disorder with mixed disturbance of emotions and conduct, delirium d/t (due to) a recent placement -noted with short term and long term memory deficits-confusion noted to increase starting in evening/afternoon - noted to sleep in open beds that are not assigned to him at times. The last updated intervention was dated 10/6/25.Review of R2's progress note dated 12/17/25 at 17:00 (5:00 PM) revealed, Resident wandering in hallway and went a short way into another resident's room, his pants had fallen to his knees. Pants were pulled up and resident redirected.R24Review of R24's admission record dated 12/17/25 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: muscle weakness, lack of coordination, and weakness. R24 was not her own responsible party.Review of R24's progress notes for 12/17/25 revealed no note of a resident entering her room or any emotional distress.Review of R24's progress note dated 12/18/25 at 5:00 AM revealed, Patient resting comfortably with eyes closed. Slept throughout night. No c/o (complaints of) pain. No concerns voiced.Review of R24's progress note dated 12/18/25 at 8:47 AM revealed, Alerted to resident room for new complains of right ear pain. Upon assessment (R24) reports that it is not her ear that hurts it is her throat that hurts from screaming. Ear is without abnormalities, no redness or warmth noted. Offered warm tea with lemon to sooth throat. She declined offer stating she only wanted her AM meds with Tylenol in it.Review of R24's progress note dated 12/18/25 at 10:57 AM, Social Services Note: SS (social services has interacted with guest four times this morning r/t (related to) her needs and allegation she made 12/17/25 r/t (related to) another guest exposing himself to her.R24 was observed in her room on 12/18/25 at 8:00 AM. R24 was very distressed about a man coming into her room the previous day after her second smoke break with his pants down. She said at first, she was not afraid because there had been another confused man that would wander into her room when she was in the bathroom, and she knew that man was just confused. When she found out it was not the same person, she was very upset. She complained of yelling so loud and for so long yesterday about (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this man in her room that her right ear was very painful at this time. The Nursing Home Administrator (NHA) was in the hall at this time. The Surveyor asked the NHA to come into R24's room and she repeated the story again. Certified Nurse Aide (CNA) R came into R24's room at this time with R24's breakfast tray. CNA R reported that during shift report she was told that R2 had been in R24's room with his pants down the previous day. R24 was so upset at this time that at first, she refused to eat. With encouragement she did allow CNA R to set up her breakfast tray.During a telephone interview on 12/18/25 at 8:23 AM, Licensed Practical Nurse (LPN) C confirmed she put the note in R2's medical record on 12/17/25 at 5:00 PM about him being in another resident's room with his pants down. LPN C confirmed that R2 was the resident in R24 room with his pants down. LPN C said CNA S informed her about the incident. LPN C said the Director of Nursing (DON) was in the building at the time of this report and she reported it to the DON. The DON told her to talk to them and document in R2's progress note. She confirmed she did not write any notes in R24's progress note. LPN C reported she did talk to R24, and she was very upset, but she was able to calm her down.During an interview on 12/18/25 at 8:45 AM, LPN U reported she started working on R24's nursing unit on 12/17/25 at 11:00 PM and it was reported to her that R24 was alleging the incident with R2 was almost rape. LPN U was still working on R24's unit at this time and was aware that R24 was still very upset about R2 being in her room with his pants down.During an interview on 12/18/25 at 8:33 AM, the DON confirmed LPN C had reported to her the previous day that R2 had been in R24's room and R2 had exposed himself to R24. The NHA and DON confirmed that this event was not documented in R24's medical record. R2 and R24's representatives were not notified. No investigation or witness statements had been taken at this time. R2 and R24 were not assessed. No interventions were implemented to ensure R24's safety.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to investigate and report an allegation of abuse to the State Agency for 2 Residents (R2 and R24) of 12 residents sampled.Findings included:R2Review of R2's admission record dated, 12/18/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: wandering, vascular dementia, and cognitive communication deficit. R2 was not his own responsible party.Review of R2's care plan dated 8/18/25 revealed, wandering/exit seeking: (R2) is at risk for exit seeking/wandering r/t (related to) dx (diagnosis) of dx TIA (stroke), cognitive communication deficit, UTI (urinary tract infection) hearing loss, adjustment disorder with mixed disturbance of emotions and conduct, delirium d/t (due to) a recent placement -noted with short term and long term memory deficits-confusion noted to increase starting in evening/afternoon - noted to sleep in open beds that are not assigned to him at times. The last updated intervention was dated 10/6/25.Review of R2's progress note dated 12/17/25 at 17:00 (5:00 PM) revealed, Resident wandering in hallway and went a short way into another resident's room, his pants had fallen to his knees. Pants were pulled up and resident redirected.R24Review of R24's admission record dated 12/17/25 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: muscle weakness, lack of coordination, and weakness. R24 was not her own responsible party.Review of R24's progress notes for 12/17/25 revealed no note of a resident entering her room or any emotional distress.Review of R24's progress note dated 12/18/25 at 5:00 AM revealed, Patient resting comfortably with eyes closed. Slept throughout night. No c/o (complaints of) pain. No concerns voiced.Review of R24's progress note dated 12/18/25 at 8:47 AM revealed, Alerted to resident room for new complains of right ear pain. Upon assessment (R24) reports that it is not her ear that hurts it is her throat that hurts from screaming. Ear is without abnormalities, no redness or warmth noted. Offered warm tea with lemon to sooth throat. She declined offer stating she only wanted her AM meds with Tylenol in it.Review of R24's progress note dated 12/18/25 at 10:57 AM, Social Services Note: SS (social services has interacted with guest four times this morning r/t (related to) her needs and allegation she made 12/17/25 r/t (related to) another guest exposing himself to her.R24 was observed in her room on 12/18/25 at 8:00 AM. R24 was very distressed about a man coming into her room the previous day after her second smoke break with his pants down. She said at first, she was not afraid because there had been another confused man that would wander into her room when she was in the bathroom, and she knew that man was just confused. When she found out it was not the same person, she was very upset. She complained of yelling so loud and for so long yesterday about this man in her room that her right ear was very painful at this time. The Nursing Home Administrator (NHA) was in the hall at this time. The Surveyor asked the NHA to come into R24's room and she repeated the story again. Certified Nurse Aide (CNA) R came into R24's room at this time with R24's breakfast tray. CNA R reported that during shift report she was told that R2 had been in R24's room with his pants down the previous day. R24 was so upset at this time that at first, she refused to eat. With encouragement she did allow CNA R to set up her breakfast tray.During a telephone interview on 12/18/25 at 8:23 AM, Licensed Practical Nurse (LPN) C confirmed she put the note in R2's medical record on 12/17/25 at 5:00 PM about him being in another resident's room with his pants down. LPN C confirmed that R2 was the resident in R24's room with his pants down. LPN C said CNA S informed her about the incident. LPN C said the Director of Nursing (DON) was in the building at the time of this report and she reported it to the DON. The DON told her to talk to them and document in R2's progress note. She confirmed she did not write any notes in R24's progress note. LPN C reported she did talk to R24, and she was very upset, but she was able to calm her down.During an interview on 12/18/25 at 8:45 AM, LPN U reported she started working on R24's nursing unit on 12/17/25 at 11:00 PM and it was reported to her that R24 was alleging the incident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with R2 was almost rape. LPN U was still working on R24's unit at this time and was aware that R24 was still very upset about R2 being in her room with his pants down.During an interview on 12/18/25 at 8:33 AM, the DON confirmed LPN C had reported to her the previous day that R2 had been in R24's room and R2 had exposed himself to R24. The NHA and DON confirmed that this event was not documented in R24's medical record. R2 and R24's representatives were not notified. No investigation or witness statements had been taken at this time. R2 and R24 were not assessed. No interventions were implemented to ensure R24's safety. The NHA said he would start the investigation now and report it to the State Agency.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to complete and maintain an Acute Transfer Log and provide this log to the Ombudsman in a timely manner. Findings include: In an interview on 12/18/2025 at 12:13 PM the Nursing Home Administrator (NHA) reported that Social Worker (SW) G completes the Acute Transfer Log (a log that is maintained with residents that are transferred to an acute care facility) and emails the log to the State Ombudsman. In an interview on 12/18/2025 at 12:18 PM, SW G reported that the NHA completes the Acute Transfer Log and emails the log to the State Ombudsman. Review of an email received from Ombudsman V on 12/18/2025 at 12:44 PM revealed the State Ombudsman office had not received an Acute Transfer Log from the facility since September of 2023.

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The Laurels of Fulton	4735 Ranger Road Perrinton, MI 48871

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop, implement, and update individualized care plans for 2 residents (R8 and R6) of 12 residents reviewed. Findings include:R6 Review of R6's admission record dated 12/17/25 revealed she was admitted on [DATE] and had diagnoses that included spastic quadriplegic cerebral palsy, hydronephrosis with renal and ureteral calculous obstruction (enlarged kidney and kidney stones in the ureter), malignant neoplasm of the lateral wall of bladder (bladder cancer) and developmental disorder of speech and language. She was not her own responsible party. Review of R6's Catheter care plan dated 3/21/25 revealed, R6 is at risk for UTI (urinary tract infection) and catheter related trauma r/t (related to) urostomy and history of MDRO's (multidrug resistant organisms). Interventions included: Ensure catheter tubing is secured. R6 was observed on 12/17/25 receiving care. When the CNA's turned R6 on side the foley bag was secured to the side of the bed and the tubing was observed to be stretched tight. RN B was in the room at this time. It was observed that R6 did not have the catheter tubing secured to her leg. RN B was asked if R6 should have the tubing secured and she said it was the facility policy. R8 Review of an admission Record revealed R8 admitted to the facility on [DATE] with pertinent diagnoses which included acute respiratory failure with hypoxia, speech disturbances, dysphagia, malignant neoplasm of larynx, tracheostomy, and major depressive disorder. Review of R8's Cognition Care Plan dated 8/14/2025 revealed R8 with intact cognition per BIMS. Review of a current Respiratory Care Plan dated 8/13/2025 revealed R8 has a potential for difficulty breathing and risk for respiratory complications relate to the use of Trach and dx of acute respiratory failure w/hypoxia. In an observation and interview on 12/16/2025 at 10:45 AM in R8's room R8 shrugged her shoulders when asked where the facility keeps the backup tracheostomy tube. R8 presented the cap to her stoma but could not locate the backup tracheostomy tube in her room. In an observation and interview on 12/16/2025 at 10:46 AM with Registered Nurse (RN) D in the East Hallway at the medication cart RN D revealed the backup tracheostomy tube for R8 was in the medication cart. RN D opened the bottom drawer to the medication cart and presented a box with R8's name on it. RN D stated the backup tracheostomy tube should be at the bedside but is kept in the medication cart. RN D stated she did not know why the backup tube was being stored in the medication cart. In an interview and record review on 12/16/2025 at 11:30 AM the Regional Nurse A revealed that R8 had a laryngectomy tube not a tracheostomy tube. Regional Nurse A provided two procedure guidelines for 1. Laryngectomy stoma and tube care and 2. tracheostomy tube cannula and stoma care describing the care of both. Regional Nurse A reported that the backup laryngectomy tube was being stored in the medication cart because R8 had behaviors including throwing things away like her (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	laryngectomy tube. In an interview on 12/17/2025 at 9:30 AM the Assistant Director of Nursing (ADON) N revealed the backup laryngectomy tube was in the medication cart related to R8's behaviors of playing with it and removing it. ADON N revealed the nurses were aware that the backup tube was in the medication cart. In an interview on 12/18/2025 at 7:59 AM the Director of Nursing (DON) was asked if R8's care plan should match R8's current medical condition and the DON stated yes. Current care plans for R8 did not direct nursing to the placement of R8's laryngectomy tube and throughout the care plan R8's laryngectomy tube was referred to as a tracheostomy. R8's Care plans did not reveal the behaviors that caused staff to change the location of the backup laryngectomy tube from the bedside to the nurse medication cart. Review of facility policy/procedure Care Planning, issued 03/03/2025 revealed .every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights. The care plan must be specific, resident centered, individualized and unique to each resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the Care Plan for one cognitively impaired Resident (R3) with behaviors and who was prescribed psychoactive medications without documented Care Plan revisions to attempt to prevent or minimize the use of psychoactive medications of five residents reviewed for Care Plan revisions.Findings include:Resident (R)3 was admitted to the facility 8/1/25 with pertinent diagnoses that included Dementia and Alzheimer's Disease. Review of the Minimum Data Set (MDS) dated [DATE] reflected R3 was severely cognitively impaired. The medical record reflected the spouse of R3 was the designated Responsible Party.Review of the Electronic Medical Record (EMR) Progress Notes revealed a Medical Provider entry dated 8/5/25 at 8:00 AM that R3 is pleasantly confused, has been noted to be exit seeking but is easily redirectable and there were No acute clinical concerns.Review of the EMR Progress Note dated 8/7/25 at12:46 AM reflected R3 is pleasantly confused wandering, and allowed redirection with a pleasant attitudeReview of the EMR Progress Note entry dated 8/7/25 at 2:23 PM reflected staff were having a hard time redirecting resident and that R3 is becoming agitated. The entry did not reflect what, if any, non- pharmacological interventions or diversions were attempted to calm or redirect R3.Review of Hospice documentation dated 8/8/25 reflected Hospice had received a call from a Facility Nurse that R3 is exit seeking and having increased agitation. The entry reflected a Doctor's Order for Ativan (also known as Lorazepam, a benzodiazepine anxiolytic (antianxiety) psychoactive medication) was implemented. The documentation reflected Hospice suggested the facility consider some ideas to help keep (R3) entertained.Review of the EMR Medical Provider entry of 8/12/25 reflected R3 was evaluated for back pain and prescribed Tylenol. The Medication section of the Medical Provider entry reflects the addition of Lorazepam 0.5 mg as needed for anxiety/agitation to the Resident's medication regimen. However, this entry did not reveal R3 had exhibited or had been evaluated for anxiety. No documentation was found that provided a basis for the use of psychoactive medication.The policy provided facility titled Psychoactive Medication Management last revised 9/7/25 was reviewed. The policy reflected Policy: The facility will provide individualized care and services that promote the highest practicable level of function by providing activity/ functional programs as appropriate and safety interventions to minimize the use of psychotic medications in managing behaviors when non-pharmacological interventions have failed. And The .team works with the resident and/or family /legal representative to determine an appropriate plan of care. And Non-pharmacological interventions are the first choice in management of behavioral symptoms. And Behavioral interventions are individualized, non-pharmacological approaches to care.Review of the Care Plan for R3 revealed plans of care for Wandering and Behavior had been initiated 8/1/25 at the time of admission. Both plans of care were without revision until 8/20/25 despite documentation of behaviors and the initiation of antipsychotic medication for behavior modification on 8/12/25. No documentation the facility attempted to personalize the plan for care for R3 prior to use of antipsychotic medication to avoid use of these medications in accordance with facility policy could be located.Review of the Behavior Care Plan for R3 reflected the Intervention to Provide a program of activities that is of interest and accommodates (R3)'s status/cognition. However, review of the entire Care Plan revealed an Activities plan of care was not initiated until 8/21/25 well after admission to the facility and the initiation of pharmacological intervention. Additionally, review of the entire Care Plan did not reveal a plan for care for antipsychotic medications had been initiated to date since the initial Doctor's Order for Lorazepam on 8/12/25 or after the Doctor's Order on 11/25/25 for Depakote for behavior modification.On 12/18/25 at 11:12 AM an interview was conducted with Assistant Director of Nursing (ADON) N. ADON N was informed a review of the Care Plan for did not reveal personalized efforts were made to address the behaviors of R3 and prevent the use psychoactive medications. ADON N (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was unable to provide documentation the Care Plan had been revised and no further information was provided by the facility.On 12/18/2025 at 1:18 PM an interview was conducted with Social Worker (SW) G. SW G was informed documentation had not been discovered of revisions to the Care Plan of R3 to manage behavioral symptoms prior to and after initiating psychoactive medications. SW G reported the facility had a team approach to behavior management and tried not to jump straight to an antipsychotic. SW G reiterated the facility used a team approach to ensure consents, care plans and evaluations had been completed but was unable to provide any documentation to support this claim for R3.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure one resident (R24) of 12 residents sampled was receiving all her activities of daily living to maintain her ability to walk.Findings included:Review of R24's admission record dated 12/17/25 revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: muscle weakness, lack of coordination, and weakness. R24's admission Record also revealed she was not her own responsible party.During an observation of cares for R24 on 12/17/25 at 8:45 AM, R24 required physical assistance to stand and transfer from her bed to her wheelchair. R24 had a wheeled walker in her room. Certified Nurse Aide (CNA) M was asked if R24 could walk. CNA M said she requires assistance, and she would ask if she wanted to walk. R24 said she did not want to walk because her right shoulder was sore. CNA M could not recall the last time she had seen R24 walk.Review of R24's Kardex (caregiver guide for care) dated 1217/24 revealed, ambulation/walking: R24 is able to ambulate w/4WW (with a wheeled walker), She uses a wheelchair for long distance locomotion/mobility. She is able to use her feet to propel herself short distances but may need staff assistance for longer distances. Encourage walk-to-dine.Review of R24's task for Walk 10 feet - encourage walk to dine from 11/18/25 to 12/16/25 revealed R24 was assisted to walk one time on 11/25/22, one-time on12/7/25 and one time on 12/9/25. There was no indication of how far she walked. It was documented that she refused to walk one time on 11/20/25, one time on 12/2/25, one time on 12/3/25, one time on 12/4/25, one time on 12/6/25, one time on 12/7/25, one time on 12/9/25, one time on 12/10/25, one time on 12/11/25, one time on 12/14/25, one time on 12/15/25, and one time on 12/16/25. There were no progress notes for these dates to show why R24 was only assisted one time on some days. In addition, on the days R24 refused to walk to dine there was no indication a licensed nurse was aware of R24's refusals to walk. There was also no documentation on why she was not assisted or encouraged to walk to dine on 11/18/25, 11/19/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/26/25, 11/27/25, 11/28/25, 11/29/25, 11/30/25, 12/1/25, 12/5/25, 12/8/25, 12/12/25, and 12/13/25.During an interview with the Director of Nursing (DON) on 12/17/25 at 1:30 PM, the DON was asked how she ensured residents like R24 were receiving walking assistance. The DON reviewed R24's electronic medical record and said R24 finished physical therapy on 12/2/25 and the note indicated she was back to walking at her prior level of function. The DON said she did not have any documentation that showed R24 had been assisted to walk or refused to walk since 12/2/25 when she was seen by physical therapy. The DON confirmed the CNAs should be assisting R24 to walk daily and if she refuses, they should document the refusal in her medical record, and a license nurse should document why R24 was refusing to walk. Prior to exit the facility provided documentation of R24's refusal to walk but did not provide any documentation that the licensed nurses or her physician was aware of the refusals or any follow up to determine the reason R24 was refusing to walk.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent the fall of 1 resident (R45) of 4 residents reviewed for falls. Findings include:Review of an admission Record revealed R45 admitted to the facility on [DATE] with pertinent diagnoses which included alzheimer's disease, dementia, and visual hallucinations. Review of a current fall Care Plan intervention for R45, initiated 12/13/2025, revealed resident required one on one supervision in anticipation of care needs. In an observation on 12/16/2025 at 11:10 AM in R45's room, R45 was observed resting in bed with a Certified Nursing Assistant (CNA) sitting at his bedside providing 1 on 1 supervision. Review of R45's Nurses Notes in the Electronic Medical Record (EMR), dated 12/13/2025 at 7:55 AM, revealed .Resident was sitting in (wheelchair) at nurse's station under 1:1 supervision. Foot pedals were in place and (wheelchair) was locked. (Resident) was noted to be in front of (wheelchair) on hands and knees, face first by this nurse. In an observation and interview on 12/17/2025 at 12:27 PM in R45's room, R45 was in bed with CNA I sitting at his bedside and providing 1 on 1 supervision of R45. CNA I reported R45 had a recent incident when he was found on the floor while in 1 on 1 supervision. CNA I reported she was not working at the time, but she was aware that it was shift change when the incident occurred. Review of R45's fall incident report, dated 12/13/2025 at 6:30 AM, revealed .Resident was sitting in wheelchair at nurses' station while 1:1 staff was charting. Was noted by nurse to be in front of chair on the floor on hands and knees, face first. In an interview on 12/17/2025 at 12:58 PM, CNA J reported she was providing 1 on 1 supervision to R45 when he was found on the floor the morning of 12/13/2025. CNA J reported R45 was in his wheelchair at the nursing station while she was documenting at a computer when he was found on the floor. In an interview on 12/17/2025 at 1:05 PM, the Assistant Director of Nursing (ADON) N reported CNA J was provided written counseling regarding how to provide 1 on 1 supervision of residents. Review of Educational Opportunity provided to CNA J, dated 12/17/2025, revealed .When assigned to a resident 1 on 1, you must be with the resident at all times to intervene. This means in close proximity enough to physically assist them and deter a fall. If you are going on break, you need to hand the resident off to another staff. Review of facility policy/procedure Fall Management, effective 7/8/2025, revealed .Each resident is assisted in attaining/maintaining his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and/or functional programs as appropriate to minimize the risk for falls.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to evaluate one cognitively impaired resident and document the rationale for use of an antipsychotic, define target behaviors, and establish goals for treatment in accordance with regulatory requirements and facility policy for one Resident (R3) of five residents reviewed for the use of psychotropic medication.Findings include:R3 was admitted to the facility 8/1/25 with pertinent diagnoses that included Dementia and Alzheimer's Disease. Review of the Minimum Data Set (MDS) dated [DATE] reflected R3 was severely cognitively impaired. The medical record reflected the spouse of R3 was the designated Responsible Party.Review of the Electronic Medical Record (EMR) Progress Notes revealed a Medical Provider entry dated 8/5/25 at 8:00 AM that R3 is pleasantly confused, has been noted to be exit seeking but is easily redirectable and there were No acute clinical concerns.Review of the EMR Progress Note dated 8/7/25 at12:46 AM reflected R3 is pleasantly confused wandering, and allowed redirection with a pleasant attitude.Review of the EMR Progress Note entry dated 8/7/25 at 2:23 PM reflected staff were having a hard time redirecting resident and that R3 is becoming agitated. The entry did not reflect what, if any, non-pharmacological interventions or diversions were attempted or implemented to calm or redirect R3.Review of Hospice documentation dated 8/8/25 reflected Hospice had received a call from a Facility Nurse that R3 is exit seeking and having increased agitation. The entry reflected a Doctor's Order for Ativan (also known as Lorazepam, a benzodiazepine anxiolytic (antianxiety) psychoactive medication) was implemented. The documentation reflected Hospice suggested the facility consider some ideas to help keep (R3) entertained.Review of the EMR Medical Provider entry of 8/12/25 reflected R3 was evaluated for back pain and prescribed Tylenol. The Medication section of this entry reflects the addition of Lorazepam 0.5 mg as needed for anxiety/agitation to the Resident's medication regimen. However, this entry did not reveal R3 had exhibited or had been evaluated for anxiety. No documentation was found that provided a historical review, justification or rational, or specific goals of prescribing a psychoactive anxiolytic to R3.Review of the medical record did not reveal documentation the responsible party for R3 had been informed of the indications for use, the rationale, the risks and benefits, or the goal of a psychoactive medication until 9/10/25. Nor did the medical record reveal the responsible party had been informed of any measures that had been attempted for behavior modification prior to initiating the Lorazepam on 8/12/25.Review of the Care Plan for R3 revealed plans of care for Wandering and Behavior had been initiated 8/1/25 at the time of admission. Both plans of care were without revision until 8/20/25 despite documentation of behaviors and the initiation of antipsychotic medication for behavior modification on 8/12/25. No documentation was found the facility attempted to personalize the plan for care for R3 to avoid the use of antipsychotic medication. Further review of the entire Care Plan revealed an Activities plan of care was not initiated until 8/21/25 well after admission to the facility and the initiation of pharmacological intervention. Additionally, review of the entire Care Plan did not reveal a plan for care for antipsychotic medications had been initiated to date since the initial Doctor's Order for Lorazepam on 8/12/25 or after the Doctor's Order on 11/25/25 for Depakote for behavior modification.The policy provided facility titled Psychoactive Medication Management last revised 9/7/25 was reviewed. The policy reflected Policy: The facility will provide individualized care and services that promote the highest practicable level of function by providing activity/ functional programs as appropriate and safety interventions to minimize the use of psychotic medications in managing behaviors when non-pharmacological interventions have failed. And Procedure.4. Residents receiving psychoactive medications upon admission, those with new psychoactive medications orders or an increase in the dose of the medication, will have a psychotropic medication informed consent completed. Before initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	warnings for the antipsychotic medications in advance of such initiation or increase. And A resident requiring a psychoactive medication will be monitored by the interdisciplinary team (IDT). The policy reflects the IDT will review behaviors .and interventions attempted. And Non- pharmacological approaches should be used before prescribing the medication.and documented in the medical record.On 12/18/25 at 11:12 AM an interview was conducted with Assistant Director of Nursing (ADON) N. ADON N was unable to identify from the medical record Medical Provider documentation of rational or a specific goal for the use of a psychoactive medication for R3. ADON N acknowledged the consent for the medication was dated 9/10/25 after the medication had been initiated. No additional documentation was provided. On 12/18/2025 at 1:18 PM an interview was conducted with Social Worker (SW) G. SW G was informed documentation of the determination for the use of psychoactive medication had not been identified in the medical record. SW G reported the facility had a team approach to behavior management and tried not to jump straight to an antipsychotic. SW G reiterated the facility used a team approach to ensure consents, care plans and evaluations had been completed but was unable to provide any documentation to support this claim for R3.As of survey exit no additional documentation was provided by the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate Electronic Health Record (EHR) for 1 resident (R45) of 12 residents reviewed for accuracy of medical records. Findings include: Review of an admission Record revealed R45 admitted to the facility on [DATE] with pertinent diagnoses which included alzheimer's disease, dementia, and visual hallucinations. Review of R45's Resident Code Status, signed 12/10/2025, revealed his status was Do Not Resuscitate (DNR). Review of R45's Physician's Orders, active 12/16/2025 at 1:00 PM, revealed no order for DNR or hospice. Further review of the EHR revealed no alert for DNR. In an interview on 12/16/2025 at 1:10 PM, Registered Nurse (RN) D reported R45 was DNR status. RN D reviewed R45's EHR and reported there was no alert or Physician's Order for DNR. RN D reported a resident who was DNR should have a Physician's Order and alert in their EHR. In an interview on 12/17/2025 at 10:21 AM, Assistant Director of Nursing (ADON) N reviewed R45's EHR and reported there was no Physician's Order for DNR or hospice care, and there was no alert for DNR status. ADON N reported R45's DNR status was signed 12/10/25. ADON N reported the Physician's Order and alert should have been placed in the EHR at that time. ADON N reported R45 signed into the care of hospice when he admitted to the facility on [DATE] and he should also have a Physician's Order for hospice. In an interview on 12/18/2025 at 1:00 PM, the Director of Nursing (DON) reported R45 had been on 1 on 1 observation for his safety from within 24 hours of his admission to the facility on [DATE]. The DON reported R45's 1 on 1 intervention was not documented in the EHR until it was placed in the Care Plan on 12/13/2025. The DON reported there was no documentation to show staff had been completing 1 on 1 observation of resident. Regional Clinical Nurse A reported the facility should have documented the 1 on 1 intervention on R45's Care Plan when this was initiated. Regional Clinical Nurse A further reported the facility should have been documenting the 1 on 1 under tasks. Review of the facility policy/procedure Medical Records Management, revised 1/31/2022, revealed .The facility must maintain medical records on each guest/resident, in accordance with accepted professional standards and practice and state and federal law. Medical records must be complete, accurately documented, readily accessible, systematically organized, and maintained. The electronic medical record is defined as containing the following items. Active, discontinued, and completed physician orders. Care plans, including resolved and cancelled.