

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Maple Woods Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 13137 North Clio Road Clio, MI 48420	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed store food in a sanitary manner and appropriately label and date food products. Findings include: On 6/1/26, at 9:15AM, an initial observation of the kitchen was completed with Dietary Manager (DM) L. The following findings were noted. Walk in Fridge:-Bacon was observed open with no open date or expiration date.-Eggs open with no open date or expiration date on the box.-Chopped Lettuce with a use by date 5/30/26.-Tomatoes with a use by date of 5/30/26.-Oranges no open date or expiration date, Cream Cheese Cups with a use by date of 5/2/26, an additional full box of 100 cream cheese cups was discarded due to no date on the box. Dish Machine: No air gap on the drain. Walk in Freezer:-Chicken patties observed open with no open date or expiration date.-Sausage links open, some loose in the box, with no open date or expiration date. On 6/1/26 at 9:40AM, observations were made of the East Nourishment room refrigerator and freezer. The following findings were noted.-Apple juice use with a use by date 5/29/26.-Hot dogs in the freezer with a use by date of 10/22/25.-Ice Cream with no receipt date or discard date. The ice cream container was open. On 6/1/26 at 9:50 am, observations were made of the [NAME] Nourishment room refrigerator and freezer. The following findings were noted.-Orange Juice with a use by date of 5/29/26.-Ice Cream open, with no receipt date or discard by date on it.-Styrofoam containers with a date of 5/27/26, discard by 5/30/26On 6/1/26 at 10:00am, observations were made of the [NAME] Dining Room reach in refrigerator. The following findings were noted.-Grape Juice with a use by date of 5/26/26.-Orange Juice with a use by date of 5/28/26.-Multiple Juices with a use by date of 5/26/26. An interview was conducted with DM L. DM L was asked how long resident items can stay in the refrigerator after they are opened. DM L stated they are good for three days. DM L discarded the resident items that were not dated or had gone past the three days. DM L was asked about the undated and expired foods in the kitchen. DM L stated we have a lot of new staff here and it is just going to take education to get everyone on the same page to make sure items are being discarded and labeled and dated properly. DM L stated they are new to the facility in the last few months and they are actively working to get the staff educated. DM L discarded the unlabeled, undated and expired foods in the kitchen refrigerator and freezer. Review of the policy titled, Food Supply Storage & Dating, revealed, Procedure: General: 1. The used by date is the last date food can be consumed. Refrigerated Storage: 9. Rotate items: first in, first out. Discard food past the used-by date. Freezer Storage: 5. Foods stored frozen and unopened should be stored no longer than 6 months for quality purposes. Food that has been opened from the original packaging is to be stored in the freezer no longer than 90 days.6 Date and rotate items; first in, first out. Review of the policy titled, Resident Food from Outside Sources, revealed: Procedure: 3. Food can be labeled with the date and the name of the resident and stored in the nourishment room refrigerator.4. Prepared foods from families and outside sources will be stored in proper storage for 3 days (2 (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 3026069. Based on observation, interview and record review, the facility failed to ensure access to and answer call lights timely for three residents (#31, #49, #106) and a Confidential Group of Residents, resulting in the lack of timely care, residents' verbalizations of dissatisfaction with care and unmet care needs. Findings include: Resident #31: On 6/1/26 at 12:05 PM, Resident #31 was observed sitting in a recliner in their room. An untouched food tray was in place on the overbed table in front of them. An interview was completed at this time. When queried why they were not eating their food, Resident #31 adamantly responded they did not like what they received and that it was inedible. When asked if they were able to request something different to eat, Resident #31 responded they could but indicated it would be quite a while before someone answered their call light. Resident #31 pressed their call light at 12:08 PM. At 12:10 PM, two staff members were observed talking in the hallway in close proximity to Resident #31's room. Resident #31 also saw the staff. Upon saying it should not be long before one of the staff answer their call light, Resident #31 chuckled and said, It (call light) might be on but that doesn't mean they are looking at it. The light in the hallway directly above Resident #31's door, signifying the Resident's call light was on, was checked to verify it was working. The staff were still talking in the hallway. After talking for a couple more minutes, the staff members walked away without answering the Resident #31's call light. When queried if they needed assistance from staff to use the restroom, Resident #31 replied, Yeah. Resident #31 was then asked if staff assist them when they need help and replied, Depends on who is working. Resident #31 did not provide further details when asked. At 12:34 PM, a Certified Nursing Assistant (CNA) walked past Resident #31's room without acknowledging and/or answering the call light. Resident #31's call light remained on and unanswered at 12:34 PM. An interview was completed with Infection Control Licensed Practical Nurse (LPN) C on 6/1/26 at 12:35 PM. When queried what an acceptable time frame is for a Resident to wait for their call light to be answered, LPN C would not provide a specific time frame and stated, Should be answered as soon as possible. When queried if almost 30 minutes was acceptable, LPN C stated, That is not okay. I will go check. No further explanation was provided. Record review revealed Resident #31 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinsons disease, left hand contracture, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required set up to total assistance to complete Activities of Daily Living (ADLs). On 6/2/26 at 4:23 PM, an interview was completed with the Director of Nursing (DON) and Clinical RN N. When queried what an acceptable length of time to wait for a call light to be answered by a facility staff member, RN N responded that it varied from resident to resident and was what the individual (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident felt was acceptable. The DON and RN N was informed of observation of Resident #31's call light being on for almost 30 minutes as well as staff standing in the hall talking and a CNA walking past without answering the light. When queried if that was acceptable, RN N verbalized it was not. Resident #49: In an interview on 06/01/2026 at 10:03 AM with Resident #49 revealed that the staff come in and shut the light off, and say they will come right back, but they don't come back. The weekends are the worst; the lights are a long time to get answered. They told Resident 49 that the light did not work outside the room. Resident demonstrated call light did work outside the room. Third shift are lazy, and don't check on us, there are a few bad apples. In an interview on 06/01/2026 at 1:51 PM, the Activities Director D brought the Resident Council meeting notes for review. The State surveyor requested concern forms from the meetings to review. In an interview and record review on 06/01/2026 at 2:48 PM with the Nursing Home Administrator (NHA) Record review of resident council meeting notes concerns was recorded on the Resident & Family Concern Reports. The surveyor requested reports to review. NHA to get resident & Family concern forms to be reviewed. Resident council meeting to be held at 1:00PM on 6/2/2026 in the East dining room. In an interview on 06/01/2026 at 3:37 PM Resident #49 Revealed: The call lights are taking longer, from half hour to an hour response time. The staff are shutting off the call light and staff don't come back- it does take the staff a long time to get what the residents want, again a half hour to an hour. At weekends the call lights are longer than 1 hour. Getting to the bathroom is slow and takes too long, the resident stated that they take a water pill and staff just tell them to wait. Record review on 06/02/2026 at 10:18 AM of Resident & Family concern forms for the last 6 months revealed that there were multiple concerns with call lights taking 30 minutes to an hour to get staff to respond. In interviews on 06/02/2026 at 1:00 PM in the East dining room confidential resident meeting with state surveyor inquired if Call light response was timely- 6 of 10 Residents acknowledged that they have waited an hour or longer to get call light assistance, and 4 of 10 stated that they had waited 20 to 30 minutes to use the restroom or get assistance. 9 of 10 residents (One did not respond) acknowledged short staffing usually over the weekends there are call-ins and no shows, the weekends are the worst for short staffing. That's when the call lights get longer waits for help. Resident #106 (R106): On 06/01/2026 at 3:46PM, R106 was asked if the facility answers call lights in a timely manner. R106 stated, no and that third shift is the worst, they will see my call light on and just stand outside of my (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. I will yell out to them that I need help, and they will just keep walking by. I have this bell I can ring as well, when I see them standing outside my door I will ring it over and over until they finally come in. R106 was asked how long it takes to get her call light answered. R106 stated that it depends on the shift and who is working, but that most times it is at least 30 minutes and sometime up to an hour.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a clean, comfortable and home-like environment to ensure that residents' room floors were clean in rooms [ROOM NUMBERS], dining room chairs were in good repair, and TV wall hangars were securely positioned, resulting in an unclean and potentially unsafe physical environment. Findings Include: On 6/2/26 an observation was made in room [ROOM NUMBER]-2. A wall-mounted television was coming loose. The top screw in the mount was out of the wall and the mount moved freely when touched. Environment On 6/1/2026 at 9:40 AM, upon entering room [ROOM NUMBER]-2 the floor in front of the resident's bed had a large rectangular brown stained floor, approximately 3 foot x 2 foot. The remainder of the floor appeared scuffed and stained as if it needed to be rewaxed. On 6/02/2026 at 9:10 AM, upon entering room [ROOM NUMBER]-1, the floor was observed to be scuffed and stained. There was food on it, and it was not clean. On 6/3/3036 at 3:15 PM, the Administrator was interviewed about the stained floors in the resident rooms [ROOM NUMBERS]. She noted it and said they would check on it. A facility policy was requested on 6/2/2026 at 4:24 PM and not received prior to exit on 6/3/2026 at approximately 4:50 PM. Dining Environment: Observation on 06/02/2026 at 12:50 PM of the [NAME] dining room noted 26 black bottoms with tan upper back dining chairs with peeling bilateral arm rest and one chair with the right-side arm rest padded piece missing, and the chair was still in use. All 26 chairs had some areas of split or peeling vinyl on the seats, backs, or arms of the chairs. Observation on 06/02/2026 at 1:03 PM of the East dining room while waiting for the resident council attendees to gather, the state surveyor observed 4 black bottoms with tan upper back dining room chairs to have the vinyl peeling of the seats, backs or arms of the chairs. In an interview on 06/02/2026 at 1:35 PM the Resident council attendees were asked about the condition of the dining room chairs Black bottoms and a tan upper back with the vinyl peeling off of them and 8 of 10 residents stated that the facility needed to repair or replace the dining room chairs and that the [NAME] dining room the chairs were even worst shape.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to operationalize policies and procedure for medication storage in two of four medication rooms and two of six medication carts, resulting in a lack of cleanliness in medication storage rooms, unsecured medications, open, undated, expired, and inappropriately stored medications. Findings include: A tour of the East Hall Medication Storage Room was completed with Registered Nurse (RN) G on 6/3/26 at 1:35 PM. Upon entering room, an oxygen tank was observed sitting to the left of the door directly on the floor and not in a holder. Multiple items were observed sitting directly on the floor including a wheelchair storage bag, a wheelchair cushion, a portable oxygen container holder for a wheelchair, a box of wound vac tubing, and open box of boost supplements, and an open box of piston syringes for tube feedings. Food was present in the medication refrigerator. The following expired medications were present in the medication room: - Two pack of Narcan spray 4 milligrams (mg); Expired: 2/2026 - Twenty-five 0.03-ounce (oz) packages of Bacitracin Zinc Ointment; Expired: 6/2023 - Eight Bisacodyl 10 mg suppositories; Expired: 2/2026 - Twelve Tylenol 650 mg suppositories; Expired: 3/2026 An unknown, live bug was observed moving across the floor in the medication storage room. During the tour, Infection Control (IC) Licensed Practical Nurse (LPN) C was asked to come into the East Hall medication room. Upon entering the medication room, IC LPN C was asked if it was okay to store items on the floor of the medication room and replied that it was not. IC LPN C was then asked to open the medication fridge and upon seeing the food items in the fridge, began to remove them. When queried if food items should be stored in the medication refrigerator, IC LPN C responded that food should not be stored in the same refrigerator as medications. A tour of the Central Hall Medication Room was completed on 6/3/26 at 2:16 PM with IC LPN C. An open and undated vial of Tuberculin (TB) Purified Protein Derivative (PPD) 5 TU (Tuberculin Units)/0.1 mL antigen solution was observed in the medication refrigerator. When queried if TB antigen solution should be dated when opened, IC LPN C verbalized it should be and would need to be disposed of. Multiple personal items, including bags, clothing, and beverages, were observed stored in a cabinet containing medications/medical supplies. When queried, IC LPN C verbalized the items belonged to nursing staff. IC LPN C was asked if nursing staff were supposed to store their personal (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	items in the medication room, IC LPN C responded they were not and removed the items. On 6/3/26 at 2:19 PM, the Central Short Hall Medication Cart was observed unlocked and unattended by staff. IC LPN C was asked if the medication cart should be unlocked and unattended and indicated the cart should be locked. A tour of the unlocked cart was completed with IC LPN C at this time. The following items were observed: - Bisacodyl 10 mg suppository; Expired: 2/2026 - Eleven Tylenol 650 mg Suppositories; Expired: 3/2026 - 0.15 oz. Tube of Lidocaine 4%; Expired Additionally, various individual snacks were stored in the bottom left-hand drawer along with a container of cleaner. When queried regarding facility policy/procedure related to expired medications, IC LPN C verbalized expired medications should be removed and disposed of. When queried if snacks should be stored in the medication cart and in the same drawer as cleaner, IC LPN C responded they should not and removed the snacks. Review of facility provided policy/procedure entitled, Medication Storage & Stability (Revised: 4/2021) revealed, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 2. Only licensed nurses, consultant pharmacist, and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. 8. Potentially harmful substances (such as test reagent tablets, household poisons, cleaning supplies, disinfectants) are clearly identified and stored in a locked area separately from medications. 13. Outdated, contaminated, or deteriorated medications. are immediately removed from stock, disposed of according to procedures for medication disposal. 14. Medications storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. Medication Storage and Labeling: In an interview and observation on 06/01/2026 at 9:25 AM with Resident #63, during the initial screening process, stated that he has watched that loose pill in the hallway all night. He stated that is where they park the 'Pill Wagon' and he should pick it up and sell it to the potheads for money. Surveyor observed a white circular tablet on the floor outside of room [ROOM NUMBER]. Observation and interview on 06/01/2026 at 9:35 AM with Registered Nurse (RN) P, was called down the [NAME] long hall to observe the white tablet on the floor. RN P bent down and picked up the table and observed a scored white circular table with No29 on the back side. RN P did not know what the tablet was or where it came from, but that is the spot where the medication cart is parked at times (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when administering medications at the end of the hallway. Observation on 6/2/2026 at 7:37AM in the [NAME] long hall of the 'Pill Wagon' parked in the spot of the loose found pill located on 6/1/2026 in the hallway. A nurse was administering medications on the west south end hallway. Observation on 06/03/2026 at 7:42 AM of the west long hallway 'Pill Wagon' medication cart was parked in the same area of the hall as the loose tablet was found. The medication cart was not in use, and the nurse was seated at the nursing station at the other end of the hall.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure palatable and appealing food for three residents (R6, R41 and R106) of five residents reviewed for food and a confidential group of residents. Findings include: Resident #106 (R106): R106 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease (COPD), chronic respiratory failure and cerebral infarction without residual deficits. On 06/01/2026 at 3:52PM, R106 was asked about the food the facility serves. R106 stated, the food is cold and she gets tired of getting cold food in her room. R106 says she has to have kitchen staff warm up items for her constantly. R106 stated that this occurs at all meals. On 06/02/2026 at 1:18PM, an interview was conducted with Dietary Manager (DM) L. DM L was asked if they have ever received complaints of cold food. DM L stated, I have and especially when I first started at the building. DM L stated the complaint is that by the time the food gets to residents in their rooms it is cold. We are losing temperature from the service area to the room. When I do get complaints, I do try to tackle them and see if there is a way we can change things or improve them. DM L was asked if the facility has insulated domes for the plates. DM L stated, yes and we have plate warmers as well. DM L stated that most of the cold food complaints comes from the west end and half of the central unit (served by west dining room). Resident #6: An interview on 06/01/2026 at 10:33 AM with Resident #6 revealed Cold foods if you eat in the rooms and that the Food is not that good. In an interview on 06/02/2026 at 8:03 AM, Resident #6 was up in her wheelchair stated that she was going to be leaving today for assisted living. When asked about the food at the facility she stated that it was not very good and most of the time the food was cold. The surveyor asked for examples of cold food items, and she stated that the eggs are cold in the mornings and the lunch if you eat in the dining room will be warm, but if she ate in the resident room the food was cold. When asked about the variety of choices the resident stated that it could be better, the other (alternative) choice menu was tiresome. Resident #49: In an interview on 06/01/2026 at 8:57 AM, Resident #49 stated that the food is cold and mushy, She does not like the food and the alternate menu takes too long to get if you request it during mealtime. Dining Observation: (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/02/2026 at 7:25 AM of the [NAME] dining room, noted 8-10 residents being served breakfast of Cinnamon French toast, oatmeal, sausage. Cook/server H and Dietary Aide I were plating the food items to trays. Observation of the tray line noted that the bottom insulated plate holder is coming off a large stack of dark blue bottoms from a shelf across from the steam table and the plates are in a stack from the plate rack with an open top and an insulated domed top is placed over the plate. The trays are placed on a rolling cart and then sent over to the beverage station for the Certified Nursing Assistance to fill the glasses and cups prior to leaving the dining room for hall trays. The rolling cart is then pushed out to the nursing units and then distributed to the resident rooms. In an observation on 06/02/2026 at 7:51 AM of the East dining room meal tray prep, the state surveyor followed a meal tray process from the meal is plated in the kitchen and placed on rolling cart. Certified Nursing Assistant (CNA) K prepped the rolling cart with beverages and then took the cart with 4 meal trays to the nursing care unit to room [ROOM NUMBER]. Random Resident #54 was presented with breakfast meal tray in her room. The state surveyor asked for permission from the resident to touch the bottom edge of the white ceramic plate and the plate was cold to the touch. There was no heat felt in the plate by surveyor. Resident #54 stated that the food is always cold. She does eat in her room most of the time. She has a cold plate, and they pour cold syrup over the French toast, and it just could be better. In an interview on 06/02/2026 at 8:00 AM, Certified Dietary Manager (CDM) L revealed that the [NAME] M plates were taken from a stack, on the counter. The cook grabbed stack of ceramic plates of 6, placed on countertop and plated food items to the plates. The CMD stated that the plates should remain in the plate warmer until ready to be used. Interviews on 06/02/2026 at 1:00 PM in the East dining room, revealed 9 of 10 residents stated that the food is cold, the plates are cold and it doesn't matter if they are in the dining room or eat in the resident room. Complaints of too much pasta, too many chicken and pork dishes, and the mashed potatoes have dry clumps from instant potatoes mix, need to be mixed more. Observation on 06/03/2026 at 7:46 AM observation of the west breakfast dining room, service is from the steam table, plate warmer was plugged in and the light was on yellow, observed cook to stack 5 plates with thermal bottoms into a stack right on top of each plate and set them on the edge of the steam table. The cook/server took time to read the meal tickets for residents prior to plating any food. An interview on 06/03/2026 at 9:09 AM with the Certified Dietary Manager (CDM) L revealed that the process it to cook everything in the kitchen and portion into steam tables pans, keep in hot oven, then 20 minutes closer to serve time the pans are place in a Cambro insulated box to take to the west dining room, and temp food items. At 7:00AM we start, we serve in dining room first, and then at 7:30 we start to shuttle out the meal trays on the tiered carts, and the CNAs put the drinks on the trays and take them to the hallway. We don't have thermal heated bottoms we just have the insulated bottoms. Yesterday the East breakfast plates were cool, the plate warmer was not on when you were watching the cook, she is our new cook and she is struggling a little, and the plates were cold. I did turn it on for her when I realized. The surveyor explained observation of the west dining room breakfast cook was Stacking the thermal bottom with a ceramic plate and would place another (continued on next page)		

Department of Health & Human Services
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NAME OF PROVIDER OR SUPPLIER Maple Woods Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 13137 North Clio Road Clio, MI 48420	
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thermal bottom and a ceramic plate on top until she had a stack of 5 on top of each other. The CDM L stated no that should not be done, as the plates get cold. The plate should not be removed from the plate-warmer until the cook is ready to plate the food.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that: 1) Ongoing surveillance for the identification of infectious organisms causing Urinary Tract Infections/UTI's to enable analysis and reporting to prevent the spread of infection and 2.) Personal Protective Equipment/PPE was worn when indicated for residents in Enhanced Barrier Precautions/EBP, resulting in a lack of compliance with infection prevention and control standards of practice. Findings Include: Infection Control On 6/03/2026 at 10:16 AM during an interview with Infection Control Practitioner/ICP C, she said she was new to the ICP role since November 2025 and someone else was the ICP before her. During the interview on 6/3/2026 at 10:20 AM with ICP C, the Infection Surveillance Line Listings dated 6/2025-5/2026, were reviewed and revealed there was a pattern of resident Urinary Tract Infections/UTI identified on the Line Listings. The UTI's were treated with an antibiotic but there was no identification of an infectious organism to ensure the most effective antibiotic was used for the resident. The Infection Line Lists were incomplete. The Infection Line Lists had columns to include the Current Prescription, Infection, Infection Site, Organism Signs and Symptoms and several additional columns. The Organism was missing on most of the UTI infections indicating there were no laboratory results for a culture (identification of the infectious organism) that coincided with a sensitivity test (identification of the most effective or resistant antibiotics) as components of a laboratory test called a Culture and Sensitivity. Without the Culture and Sensitivity results identifying the infectious organism and appropriate antibiotics to treat the infection, there would be uncertainty whether the antibiotics prescribed were appropriate and cure the infection. If the antibiotics were ineffective, it could lead to growth of resistant microorganisms. Upon review of the Infection Line Lists from June 2025 through June 2026, there were 99 suspected UTI's identified and 54 did not identify an organism to ensure the appropriate treatment was provided: 54/99, 54.5% of the suspected UTI's were lacking Culture results from a Culture and Sensitivity test. This included 37 of 61 suspected UTI's from June 2025-December 2025 with 10/14 in August 2025 and 9/11 in September 2025. There were 17 of 38 suspected UTI's from January 2026 to June 2026 that did not have Culture results identifying an organism. On 6/3/2026 at 10:30 AM, the ICP C was interviewed and asked about the incomplete Infection Surveillance and the lack of identifying laboratory results for the Culture and Sensitivity tests for UTI's and she said she couldn't speak to the issue prior to her start in the role in November 2025, but the ICP said sometimes the antibiotics were started by the Medical Provider prior to obtaining a urinalysis and sending it to the laboratory for identification and Culture and Sensitivity testing with results. Also, she said some of the listings were a result of residents admitting to the facility with a diagnosis of UTI with antibiotic treatment and the infectious organism was not made available to the facility to track to ensure appropriate antibiotic treatment. The ICP was asked about the lack of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	analysis of the UTI's without the identifying organisms to prevent the spread of infection. The ICP was able to track the number of suspected UTI's but not the organisms responsible for the infections or to identify if they were resistant organisms including Multi-Drug Resistant Organisms/MDRO's. A review of the facility document titled, Infection Prevention and Control Assessment Tool for Long-term Care Facilities, undated provided . The facility has a process for reviewing infection surveillance data and infection prevention activities., this was checked Yes; The facility has a written surveillance plan outlining the activities for monitoring/tracking infections occurring in residents of the facility, this was check Yes. Resident #53: Observation and interview on 06/01/2026 at 9:20 AM with Registered Nurse (RN) P of Resident #53's peg tube observation noted a pre-opened saline flush 30 ml syringe opened and left at bedside, and a half full 100ml normal saline bottle at bedside, with no date opened. RN P came into the room and applied gloves, handled the skin cleanser bottle and a 4x4 gauze, applied the skin cleanser to the peg tube site and wiped. Observation of the peg tube site revealed the tube to be sutured in place into the skin, size 18 French tube. Observation of left side colostomy bag intact. Observation with RN P noted a Foley catheter bag with urometer not in a privacy bag. Observed with urometer chamber full of yellow liquid. RN P removed gloves and replaced with another pair of gloves to empty the urometer chamber into the larger Foley bag, then opened the Foley clamp and a puddle formed under bed, before the nurse could get the urinal in place. The Foley catheter was emptied into a urinal. RN P did not alcohol wipe the Foley spout prior to emptying or after emptying, proceeded to clamped shut spout and placed back into slide holder. Nurse P did not use a gown or handwash while providing direct care for peg site and Foley catheter emptying. Upon exiting the room, the surveyor noted that there was no Enhanced Barrier Precaution (EBP) sign posted outside the room to notify staff to use appropriate Personal Protective Equipment (PPE). Observation on 06/02/2026 noted that there was still no Enhanced Barrier Precaution (EBP) signposted outside the room to notify staff to use appropriate Personal Protective Equipment (PPE). Record review of the facility 'Enhanced Barrier Precautions' policy, dated 3/2025, revealed it is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions are an infection control intervention designed to reduce transmission of multi-drug-resistant organisms (MDROs) in nursing homes. Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices (peg tube, foley catheter)). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 06/03/2026 at 12:28 PM with the Licensed Practical Nurse (LPN) Infection Control Preventionist (ICP) C regarding the procedure for direct care of residents with Foley catheters including enhanced barrier precautions should start with room/door signage, Urinary catheter emptying procedure- knock at door let them know what will be happening, wash hands and apply gown and gloves, provide privacy. Take the catheter bag out of privacy bag, have two alcohol wipes and a barrier for the floor, place the barrier between the graduate and floor, wipe end of spout on catheter with an alcohol wipe scrub 2-3 seconds, unclamp drain spout, draining urine into graduate container, clamp the spout and alcohol wipe end of spout, place in catheter bag, slide holder, look at urine (color, odor) and if different let nurse know, measure the urine and dump. Need to use a clean graduate container. ICP C stated that yes, staff can use a urinal, but it needs to be wash out or rinsed clean. The State surveyor took the ICP C to room [ROOM NUMBER] for observation on 06/03/2026 at 12:41 PM to observe no Enhanced Barrier Precaution (EBP) no signage on door. There was a magnetic hook up high on the door with nothing hanging on it.		

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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 obtain informed consent for psychotropic medications for one resident (R76) of two residents reviewed for psychotropic medications. Findings include: Resident #76 (R76): R76 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include major depressive disorder and Alzheimer's disease. On 06/03/2026 at 8:36AM, record review revealed a physician's order for Ativan 0.5mg, one tablet by mouth four times a day for anxiety. The start date on the order was 3/26/26. Additional orders of Ativan that have been discontinued were reviewed. On 06/03/2026 at 8:39AM, record review revealed an informed consent for Ativan 0.5mg every six hours as needed. The date on the form is 9/16/25.-Ativan 0.5mg by mouth two times a day, starting 9/17/25, discontinued 12/25/25.-Ativan 0.5mg by mouth three times a day, starting 12/25/25, discontinued 3/26/26. On 06/03/2026 at 9:49AM, an interview was conducted with Social Work (SW) O. SW O was asked when informed consents are being completed. SW O stated, we get informed consent at the time of the start of the medication and any change of the medication. SW O was asked to describe what a change in medication meant. SW O stated it can be any change in dose or the number of times it's administered. SW O was asked why they thought those were missed. SW O stated, the previous SW may have just missed them. Review of the policy, Psychotropic Medication Gradual Dose Reduction (GDR) Guidance, revealed: Procedure: 13. The residents and/or resident authorized representative will be informed of the of the initiation of a psychotropic medication, the reason for use and the risks associated with the use of psychotropic medications.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the advance directive form was completed and signed by a competent individual for one resident (#2) of 12 residents reviewed. Findings include: Resident #2: Record review revealed Resident #2 was originally admitted to the facility on [DATE] with diagnoses which included borderline personality disorder, mild intellectual disabilities, opioid dependence, Post Traumatic Stress Disorder (PTSD), and dependence upon dialysis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required set-up to no assistance to complete Activities of Daily Living (ADLs). Review of Resident #2's Electronic Medical Record (EMR) revealed a Physician Determination of Decision-Making Capability form specifying the Resident was Not capable of participating and/or making Medical Treatment Decisions for themselves. The form was signed by a Physician/Licensed Psychologist on 12/12/25 and the Attending Physician on 12/29/25. Documentation of a Durable Power of Attorney (DPOA) and/or Legal Guardian was not present in the Resident's EMR. Further review of Resident #2's EMR revealed an Advance Directive (AD) Resident Preferred Treatment Option form dated 1/15/26. The AD form was completed and signed by Resident #2 and witnessed by two facility staff on 1/15/26. Note: The AD form included a section with the option, The resident is not capable of making decisions and had no legal representation. but the section had not been utilized. An interview was completed with Social Worker (SW) O on 6/2/26 at 3:01 PM. When queried regarding Resident #2 being deemed incompetent on 12/29/25 and signing their AD form on 1/15/26, SW O stated, I can't speak to that, but I will take a look and get back to you. A follow-up interview was completed with SW O on 6/3/26 at 12:47 PM. When queried if they had an opportunity to review the AD and competency documentation in Resident #2's EMR, SW O responded they had. When queried, SW O stated, When (Resident #2) signed those forms, they were deemed incompetent. SW O was then asked if that was appropriate and per facility policy/procedure, SW O responded, No, that is not appropriate. When queried if they understood the concern, SW O stated, I'm aware. When queried why Resident #2 did not have a legal guardian when they had been deemed incompetent in December 2025, SW O stated, The facility was trying to get a public guardianship and the guardian company refused (Resident #2). SW O was asked when a request for public guardianship was filed, SW O stated, I followed up on 3/5/26 in my (EMR) note. No further explanation was provided. A facility policy/procedure related to advance directives and competency was requested at this time but not received by the conclusion of the survey.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide documentation of adequate notice of Medicare Part A benefits non-coverage, including an Advance Beneficiary Notice of Non-Coverage for 2 residents (#20 and #101) of 3 Residents reviewed for notice of non-coverage of Medicare Part A benefits, resulting in the resident's inability to exercise the right to file an appeal in a timely manner. Findings include: Beneficiary Notification On 6/02/2026 1:00 PM during an interview with the Administrator, she said Business Office Manager Q was the person responsible for providing the Notice of Medicare Non-Coverage/NOMNC letters and Advance Beneficiary Notices/ABNs to Residents receiving Skilled Medicare Part A benefits when the Skilled care was going to be completed. She said the Business Office Manager Q did not know she was supposed to track the ABN/NOMNC and was working on compiling a list of residents who she had notified and provided a letter to. On 6/02/2026 at 1:20 PM, Business Office Manager Q was interviewed. She provided a list of discharged residents from skilled care/Part A services. She said she was assigned the task in November 2025 and did not know she was supposed to issue a letter of ABN until March 2026. Upon review of three residents, two Resident #20 and Resident #101 did not receive the required notification that their skilled care services were to end, what the cost of their stay at the facility would be, and that they had a right to appeal. Resident #20: Resident #20 was admitted to the facility on [DATE] after a fall with fracture and the last covered day of skilled care was 5/20/26. The NOMNC and ABN form were provided to the resident and signed by the resident's representative on 5/15/26, but the ABN was incomplete. There were 3 options for the resident/representative to choose from, including an appeal to the discontinuation of the services and start of resident pay for the care in the facility. None of the options were chosen. Resident #101: Resident #101 was admitted to the facility on [DATE]. A NOMNC was provided to the resident/representative and signed by the representative on 2/20/2026 acknowledging the last covered day of Medicare skilled care coverage was 2/23/2026. An Advance Beneficiary Notice of Non-Coverage/ABN was not provided to the resident/representative to inform the resident/representative of the cost of services if the resident agreed to pay for them, or to appeal the decision. On 6/02/2026 at 1:54 PM, during an interview with the Business Office Manager Q she said she issued the NOMNC's to the residents/representatives but was not consistent with providing the Advance Beneficiary Notice of Non-Coverage/ABN's. On further review of the list of Residents who had received Medicare Part A skilled care benefits at the facility from January 2026- May 2026, 10 residents/representatives did not receive an ABN when Medicare Part A skilled care benefits were ending. A review of the facility policy titled, Advanced Beneficiary Notice, effective date April 2004 and revised November 2022 provided, It is the policy of this facility to prepare and deliver to the resident or residents authorized representative an Advanced Beneficiary Notice (ABN) and Notice of Medicare Non-Coverage (NOMNC) when the utilization review entity expects that Medicare probably will not pay for or will not continue to pay for extended care items or services. Purpose: To ensure that beneficiaries receive adequate notice of liability to pay for services denied by the fiscal intermediary. To provide a beneficiary the right to an expedited determination process to dispute the end of their Medicare covered care.		

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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. Based on interview and record review, the facility failed to add interventions for weight loss for one resident (Resident #49). Record review of the facility 'Care Planning Process: Admission, Comprehensive & Short Term' policy dated 11/2017 revealed it is the policy of this facility to utilize short term care plans if indicated for short term conditions that may warrant increased assessment & observation. The purpose was to ensure prompt assessment and deliver high standard person-centered care and to communicate resident needs. To ensure the results of the comprehensive assessment are used to develop, review, and revise the resident's comprehensive plan of care. 3.) Care plans are initiated to address interventions for prevention of functional decline, rehabilitative and restorative care, health maintenance issues, skin care, discharge potential, safety and wandering/exit seeking behavior, nutritional Resident #49: Record review of Resident #49's weight log task revealed fluctuation in weights On 01/22/2026, the resident #49 weighed 259 lbs. On 01/29/2026 seven days later, the resident #49 weighed 245.9 lbs. which is a -5.06% Loss in 7 days. Record review of nutrition care plan had no additional interventions added. Record review of Resident #49's progress notes revealed that there were no notes addressing a 13.1-pound weight loss. On 02/5/2026, the resident #49 weighed 257 lbs. On 02/12/2026 seven days later, the resident #49 weighed 233.0 lbs. which is a 24-pound weight loss in 7 days. Record review of nutrition care plan had no additional interventions added. Record review of Resident #49's progress notes revealed that there were no notes addressing a 24-pound weight loss. On 03/05/2026, the resident #49 weighed 252.4 lbs. On 03/12/2026, the resident #49 weighed 241.6 lbs. which is a 10.8-pound loss or -4.28% Loss in 7 days. Record review of nutrition care plan had no additional interventions added. Record review of Resident #49's progress notes revealed that there were no notes dated 3/12/2026 addressing a 10-pound weight loss. Record review of Resident #49's nutritional dietary note, dated 3/22/2026, revealed Resident #49 had a weight loss of 10.4 lbs., in less than 30 days, 41% loss, 8.6# gain in 90 days, 30.4# loss since admission/90 days. Resident is on a regular diet, with thin liquids. Feeds self. Remains on steroids, Cymbalta, and edema in bilateral lower legs. Has diagnosis of heart failure- weight fluctuation is due to that. Resident also would like to see dentists for loose dentures. Resident was visited during lunch time and ate 100% of the alternate that she requested Nutritional quarterly update: 4/23/2026 diet order general, mechanically altered diet, thin liquids. Resident is consuming 75% of most meals. Weight trend: 4/16/2026 250 lbs., 3/12/2026 241.6 lbs., 1/29/26 245.9 lbs. No significant weight changes noted recommend continuing with current diet as ordered. On 05/07/2026, the Resident #49 weighed 257.6 lbs. On 05/12/2026, the Resident #49 weighed 240.2 lbs. which is a 17.4-pound weight loss in -6.75% Loss in 6 days. Record review of nutrition care plan no interventions added. Record review of Resident #49's progress notes revealed that there were no notes dated 5/12/2026 addressing a 17.4-pound weight loss. Record review of Resident #49's nutritional care plan dated initiated on 1/19/2026 interventions included: Assess and document hydration assessment prn; skin turgor, dry mucous membranes Date Initiated: 01/19/2026 Evaluate laboratory values in relation to nutritional needs prn Date Initiated: 01/19/2026 Evaluate significant weight change with routine weights Date Initiated: 01/19/2026 Nutritional Supplements per Dietary Assessment Date Initiated: 01/19/2026 Refer to ADL flow sheet for diet specifications Date Initiated: 01/19/2026 Registered Dietician evaluation prn Date Initiated: 01/19/2026 Review preferred treatment options related to tube feedings prn Date Initiated: 01/19/2026 Serve Diet as ordered Date Initiated: 01/19/2026 In an interview and records review on 06/03/2026 at 10:11 AM, Registered Dietitian (RD) E stated that she (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started at the facility on 4/6/2026 and has been getting to know the residents, she works 3 days a week at the facility. The RD E stated that back in January 2026 through April 2026 there was an agency RD or regional corporate RD covering the building at that time. So, the monitoring of the weight loss was to be done by the corporate RD. RD E stated that Resident #49 is on her list to see today. Record review of the nutritional notes revealed that there were 3/ 22/2026 and on 4/23/2026 notes, but no recommended care plan interventions. The RD E and state surveyor reviewed Resident #49's weight log and care plan interventions together and there were no updated interventions since 1/19/2026.		

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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 observation, interview and record review, the facility failed to ensure the provision of Activities of Daily Living (ADL) care to one resident (Resident #51) of five residents reviewed, resulting in lack of oral and nail care for a dependent resident. Findings include: Resident #51: Record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses which included heart failure, weakness, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and required maximum-to-total assistance to complete all ADLs with the exception of eating. On 6/2/25 at 1:24 PM, an observation of Resident #51 was completed with Registered Nurse (RN) G in the Resident's room. Resident #51 was confused, did not provide meaningful verbal responses when asked questions, and did not follow instructions. The Resident's teeth were observed to have a visible and significant accumulation of gray/green colored thick and viscous substance. When the Resident opened their mouth, thick stands of the substance visible on the Resident's teeth were observed stretching from their top to bottom teeth. RN G observed Resident #51's mouth at the same time and verbalized the Resident desperately needed oral care. A black colored, unknown substance was observed under the Resident's nails. When queried regarding the lack of oral care for Resident #51, RN G revealed the Resident is confused and does understand which makes care more difficult to provide but the lack of oral care was unacceptable. When queried regarding the black substance under the Resident's nails, RN G was unable to state what the substance was. Review of Resident #51's Documentation Survey Report for May 2026 revealed no documentation for oral care completion. An interview was completed with the Director of Nursing (DON) and Clinical Support Registered Nurse (RN) N on 6/2/26 at 4:23 PM. When queried if dependent residents should receive assistance to complete oral care, both the DON and RN N confirmed they should. The DON and RN N were then informed of observation of Resident #51's teeth and nails. When queried regarding the lack of oral and nail care, the DON indicated they would address the concern.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform timely skin assessments for one resident (R17) of two residents reviewed for skin conditions, resulting in missed skin assessments and the potential to not identify changes in skin integrity. Findings include: Resident #17 (R17): R17 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dehydration, diarrhea, heart disease and weakness. On 06/01/2026 at 1:09PM, observation revealed that R17 has a sore on the left side of her nose. R17 stated that it was a cancerous lesion and that sometimes she will pick at it. On 06/03/2026 at 9:32AM, record review revealed that skin assessments were not completed from 3/26/26 to 5/4/26 for R17. On 06/03/2026 at 10:13AM, an interview was conducted with the Director of Nursing (DON). The DON was asked how often skin assessments are performed for residents. The DON stated they are done once weekly. The DON was asked why there was a gap in skin assessments being completed from 3/26/26 to 5/4/26 for R17. The DON stated, I cannot explain why they were missed; R17 was present in the building during those times. The DON stated they keep a list of skin assessments at the nurse's station that need to be completed weekly. Review of the policy titled, Skin at Risk Assessment, Documentation, Staging and Treatment, revealed: Procedure: 6. The following guidelines are reviewed and implicated as indicated for each individual risk factor: a. Daily skin inspections with am and pm care.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that Restorative Nursing services were provided for 1 resident (Resident #95) of 2 residents reviewed for mobility. Findings Include: Resident #95: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #95 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: heart disease, kidney disease, diabetes, hypothyroidism, and arthritis. The MDS assessment, dated 3/25/2026, revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed partial to moderate assistance with sit to stand and transfers and walking greater than 50 feet. The resident needed substantial/maximal assistance with walking distances 150 feet or greater The MDS assessment for Resident #95 dated 7/12/2024 indicated the resident needed supervision/touch assistance with ambulation of 10 feet, 50 feet and 150 feet. The MDS assessment for Resident #95 dated 6/20/2025 indicated the resident needed partial to moderate assistance with ambulating/walking 10 feet and 50 feet and was dependent with ambulation for 150 feet. Resident #95 had declined from 2024 to 2025. On 6/01/2026 at 9:41 AM, Resident #95 was observed sitting in a wheelchair in her room. She said she didn't walk anymore and stated, They got rid of the walking program. The resident said she would like to walk and stated, I think it would take 2 people to walk with me, and they might not have enough staff. On 6/03/2026 at 10:08 A, during an interview with Therapy Manager T, she was asked if the facility had a Restorative nursing program. She said after a resident finished therapy, if restorative services were needed, a therapist would develop a plan for it and give it to the Unit Manager/UM. The UM would place the plan in the resident's chart for the Nurse Aides to follow. The Therapy Manager T said each unit had a binder with Restorative tab and the Nurse Aides were to check to see if a Resident had a plan. The Therapy Manager T said Resident #95 had an ambulation plan. A record review of the Tasks documentation in the electronic medical record/emr for Resident #95 identified Restorative-ROM (range of motion) and Restorative- Splint/Brace Assistance. A review of the past 30 days until 6/3/2026 indicated there was no documentation that Resident #95 received assistance with either task. There was no Restorative- Ambulation entry. On 6/03/2026 at 1:40 PM, during an interview with Unit Manager/UM U, she said there was a list of residents in the Communication book under the Restorative tab for ambulation. The document was viewed with the UM U and it provided. The Initial Date of Program was 2/17/26 with a heading for Cont. (continue); Date Reviewed- 4/29/26 and 5/27/26: each entry said Cont. (continue). The Tasks documentation was reviewed with the UM, and she said the resident was not receiving Restorative services for ROM or a Splint or Brace. She acknowledged there was no entry for Restorative- Ambulation. She said the resident was listed on the document to have Restorative ambulation. She said the program is usually 6-8 weeks long and the resident is re-evaluated during that time. Unit Manager U said a plan for Restorative ambulation was not on Resident #95's Care Plan. On 6/03/2026 at 2:24 PM, the Director of Nursing/DON was interviewed about the facilities Restorative Nursing program and said he was not sure about the Restorative program. When asked if there was a Restorative nurse responsible for the Restorative program, the DON said he was not sure and was just learning about it.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to assess and monitor weights and ensure that interventions to promote nutrition and prevent weight loss were in place for one resident (Resident #49) of 3 sampled residents reviewed for food and nutrition. Findings include: Record review of the facility's 'Weight Management' policy, dated 4/2015, revealed it is the policy of the facility that resident's weight will be monitored by the IDT (Interdisciplinary Team) in accordance with the nutritional plan of care. 5.) in the event of a patterned significant unplanned weight loss/gain the IDT team is responsible for assessing and implementing individualized interventions. (a.) Parameters for evaluating significance of unplanned or undesired weight loss/gain are: i. 5% in 30 daysii. 7.5% in 90 daysiii. 10% in 180 days iv. Or insidious loss over a prolonged period. 6.) The nutritional plan of care is evaluated a minimum of quarterly and indicated to determine if current interventions are being followed and if they are effective in attaining nutritional and weight goals. Resident #49:Record review of Resident #49's weight log task revealed fluctuations in weightsOn 01/22/2026, Resident #49 weighed 259 lbs. On 01/29/2026 seven days later, Resident #49 weighed 245.9 lbs. which is a -5.06% Loss in 7 days. Record review of nutrition care plan had no additional interventions added. Record review of Resident #49's progress notes revealed that there were no notes addressing a 13.1-pound weight loss. On 02/5/2026, Resident #49 weighed 257 lbs. On 02/12/2026 seven days later, Resident #49 weighed 233.0 lbs. which is a 24-pound weight loss in 7 days. Record review of nutrition care plan had no additional interventions added. Record review of Resident #49's progress notes revealed that there were no notes addressing a 24-pound weight loss. On 03/05/2026, Resident #49 weighed 252.4 lbs. On 03/12/2026, Resident #49 weighed 241.6 lbs. which is a 10.8-pound loss or -4.28% Loss in 7 days. Record review of nutrition care plan had no additional interventions added. Record review of Resident #49's progress notes revealed that there were no notes dated 3/12/2026 addressing a 10-pound weight loss. Record review of Resident #49's nutritional dietary note, dated 3/22/2026, revealed resident #49 had a weight loss of 10.4 lbs., in less than 30 days, 41% loss, 8.6# gain in 90 days, 30.4# loss since admission/90 days. Resident is on a regular diet, with thin liquids. Feeds self. Remains on steroids, Cymbalta, and edema in bilateral lower legs. Has diagnosis of heart failure- weight fluctuation is due to that. Resident also would like to see dentists for loose dentures. Resident was visited during lunch time and ate 100% of the alternate that she requested Nutritional quarterly update: 4/23/2026 diet order general, mechanically altered diet, thin liquids. Resident is consuming 75% of most meals. Weight trend: 4/16/2026 250 lbs., 3/12/2026 241.6 lbs., 1/29/26 245.9 lbs. No significant weight changes noted recommend continuing with current diet as ordered. On 05/07/2026, Resident #49 weighed 257.6 lbs. On 05/12/2026, Resident #49 weighed 240.2 lbs. which is a 17.4-pound weight loss in -6.75% Loss in 6 days. Record review of nutrition care plan no interventions added. Record review of Resident #49's progress notes revealed that there were no notes dated 5/12/2026 addressing a 17.4-pound weight loss. Record review of Resident #49's nutritional care plan dated initiated on 1/19/2026 interventions included: Assess and document hydration assessment prn; skin turgor, dry mucous membranes Date Initiated: 01/19/2026 Evaluate laboratory values in relation to nutritional needs prn Date Initiated: 01/19/2026 Evaluate significant weight change with routine weights Date Initiated: 01/19/2026 Nutritional Supplements per Dietary Assessment Date Initiated: 01/19/2026 Refer to ADL flow sheet for diet specifications Date Initiated: 01/19/2026 Registered Dietician evaluation prn Date Initiated: 01/19/2026 Review preferred treatment options related to tube feedings prn Date Initiated: 01/19/2026 Serve Diet as ordered Date Initiated: 01/19/2026 In an interview and records review on 06/03/2026 at 10:11 AM (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Registered Dietitian (RD) E stated that she started at the facility on 4/6/2026 and has been getting to know the residents, she works 3 days a week at the facility. The RD E stated that back in January 2026 through April 2026 there was an agency RD or regional corporate RD covering the building at that time. So, the monitoring of the weight loss was to be done by the corporate RD. RD E stated that Resident #49 is on her list to see today. Record review of the nutritional notes revealed that there were 3/ 22/2026 and on 4/23/2026 notes, but no recommended care plan interventions. The RD E and state surveyor reviewed Resident #49's weight log and care plan interventions together and there were no updated interventions since 1/19/2026.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store and maintain respiratory equipment in a sanitary manner and ensure oxygen administration as ordered for three residents (R5, R106, R116) of three residents reviewed for respiratory care. Findings include: Resident #5: On 6/1/26 at 10:21 AM, Resident #5 was observed sitting in a recliner in their room. A Continuous Positive Airway Pressure (CPAP) mask was laying exposed and uncovered on top of a visibly soiled blanket on the Resident's recliner. The Resident had oxygen in place via nasal cannula (NC) at 3.5 liters (L) per minute. An interview was completed at this time. When queried regarding cleaning and storage of their CPAP mask, Resident #5 revealed they take it off and do not have a specific place where they store it. Resident #5 was asked how often facility nursing staff clean the mask and machine and indicated they had not seen staff clean the equipment. Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses which included anxiety and diabetes mellites. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required stand by to substantial assistance to complete Activities of Daily Living (ADLs). Review of Resident #5's Health Care Provider (HCP) orders in the Electronic Medical Record (EMR) revealed the following orders: - Oxygen: Maintain O2 (oxygen) at 2L via nasal cannula to sustain SpO2 (oxygen saturation) of 91% or greater. Check saturation level Q (every) shift (Ordered: 6/1/26) - CPAP. Cleaning: every day shift for Respiratory Equipment Mask cushion / nasal pillows: wash with mild soap and warm water; rinse and air-dry. Humidifier chamber: empty remaining water each morning; let air-dry (Ordered: 4/26/26) - CPAP. Cleaning: every day shift every 7 day (s) Tubing / hose: wash in warm soapy water, rinse well, hang to air-dry. Headgear/chinstrap: hand-wash hang to air-dry. (Ordered: 4/26/26) Resident #116: On 6/1/26 at 10:12 AM, Resident #116 was observed sitting in their room. The Resident was receiving supplemental oxygen via NC. The oxygen tubing was not dated. A nebulizer machine with connected administration set was sitting on the top of the Resident's dresser. The nebulizer administration set was connected and exposed with visible fluid present in the medication chamber. An interview was completed at this time. When queried, Resident #116 verbalized they wear oxygen via NC continuously. When queried how often they receive nebulizer treatments, Resident #116 replied, Last one yesterday. I haven't got one yet (this morning), probably because I haven't said anything yet. When queried if staff clean and dry the nebulizer administration set after use, Resident #116 did not (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide a response. Record review revealed Resident #116 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), pulmonary embolism (blood clot in lung), and pneumonia. Review of Resident #116's admission Assessment dated 5/29/26 revealed the Resident was alert and orientated X 4 (person, place, time, and situation) and had a normal gait. An interview was completed with the Director of Nursing (DON) and Clinical RN N on 6/2/26 at 4:38 PM. When queried regarding facility policy/procedure related to nebulizer equipment and maintenance following treatment administration, the DON stated, Should rinse it out and let (air) dry. After being informed of observations of Resident #116's nebulizer administration set, the DON did not provide an explanation. When queried regarding storage and cleaning of CPAP masks, the DON revealed the mask should be cleaned and air dried on a barrier. The DON was then informed of the observation of Resident #5's oxygen flow rate and the rate not matching the order. When queried, the DON indicated the administration rate should match the ordered rate. Review of facility policy/procedure entitled, Oxygen Use; Storage & Handling of Concentrators & Compressed Gas Cylinders (Revised: November 2010) revealed, Policy. Oxygen delivery will be according to physician order. Resident #106: R106 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease (COPD), chronic respiratory failure and cerebral infarction without residual deficits. On 06/01/2026 at 4:00PM, observation revealed a nebulizer mask next to the bed, it was stored intact with fluid in the medication chamber. The tubing on the nebulizer was dated 5/15/26. R106 sated that she last had a breathing treatment around 10am the morning of 06/01/26. On 06/01/2026 at 4:15PM, an interview was conducted with Unit Manager (UM) J. UM J was asked how often the tubing is changed for nebulizers. UM J replied that the tubing is changed weekly. UM J was asked what the process is for nebulizers after the treatment is completed. UM J stated that the nurses are supposed to take the nebulizer apart, rinse it out and allow it to dry on a paper towel after the treatment is completed. The findings of the dating on the tubing and nebulizer with medication still in the nebulizer were verified with UM J. UM J stated they would take care of the tubing and nebulizer right away. On 06/02/2026 at 8:57AM, observation revealed a nebulizer intact on the bedside table, fluid was noted in the medication chamber. Review of the policy titled, Small Volume Nebulizer Treatment and Compressor Care, revealed: Care of the Nebulizer Mask/Mouthpiece: (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After each treatment, rinse the nebulizer cup and delivery system with warm water, rinse thoroughly. Shake off excess water and let it air dry on a clean water absorbent barrier placed on a counter or table. The tubing is stored in a bag between use. Tubing and nebulizer delivery system are weekly and PRN (as needed).		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and operationalize policies and procedures to ensure comprehensive assessment and care of dementia for one resident (#51) of one resident reviewed resulting in a lack of implementation and revision of personalized and meaningful non-pharmacological interventions and care approaches to attain and promote the highest practicable well-being. Findings include: Resident #51: Record review revealed Resident #51 was originally admitted to the facility on [DATE] with diagnoses which included dementia with other behavioral disturbances, depression, and difficulty walking. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and required maximum to total assistance to complete all Activities of Daily Living (ADLs) with the exception of eating. The MDS further detailed Resident #51 displayed no behaviors and had no limitations in Range of Motion (ROM). On 6/2/26 at 12:50 PM, Resident #51 was observed being pushed in a wheelchair in the Hallway of the facility. The Resident was positioned in a regular wheelchair footrests, but their legs and feet were behind the footrests. Resident #51's feet did not touch the floor. On 6/2/26 at 1:00 PM, Resident # 51 was observed in the hallway of the facility near the East Hall Dining Room. The Resident was yelling out loudly and constantly. The Resident was not verbalizing and sensical words while yelling. They were sitting in the same wheelchair with their knees bent and legs behind the footrests. The Resident's feet were still not touching the floor, and their back was not positioned against the back of the wheelchair. The Resident's body was tense; they were displaying facial grimacing and looked discernibly uncomfortable. During a confidential group interview on 6/2/26 at 1:00 PM in the East Hall Dining Room, three out of three residents who reside on the East end of the building verbalized concerns regarding Resident #51 screaming throughout the day. The confidential residents disclosed Resident #51 starts screaming at 1:00 AM and continues until the afternoon. Throughout the confidential group meeting, Resident #51 was able to be heard screaming with the dining room doors closed. From 1:00 PM to 1:24 PM, Resident #51 remained sitting in the hallway, in the same position in the wheelchair, and continuously yelling out. During this timeframe, several staff members walked past the Resident without acknowledging them and/or attempting to assist them. One staff member was observed stopping, touching Resident #51's arm, telling them they were okay, and walking away while the Resident continued to yell out. An interview was completed with Registered Nurse (RN) G on 6/2/26 at 1:24 PM. When queried regarding Resident #51 yelling out, RN G stated, I think (Resident #51) has pain. RN G revealed Resident #51 due for medications at this time and began to prepare medications for administration. With further injury, RN G verbalized the Resident's pain medications had been adjusted. When queried regarding non-pharmacological interventions for pain, RN G indicated they were unaware of any interventions. RN G was queried regarding the Resident's cognitive status and ability to verbalize needs and pain levels and responded that Resident #51 had dementia, was very confused, and dependent upon staff to meet their needs. Resident #51 continued to yell out while RN G prepared the medications and during interview. Following preparation of the medications and interview, Certified Nursing Assistant (CNA) S approached the Resident and told them, It's okay but the Resident continued to yell out. CNA S was observed attempting to bend the Resident's knees to move their legs forward and place them on the footrests. Resident #51 yelled out louder and displayed facial grimacing while CNA S moved them. The Resident's knees remained flexed and bent, and the Resident's buttocks moved forward more while their upper back moved back in the wheelchair. RN G (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked CNA S if they were taking Resident #51 back to their room and CNA S responded that they were. Resident #51 continued to yell and scream out while CNA S propelled them down the hall to their room. An observation of the Resident with RN G in the wheelchair revealed the Resident's buttocks and lower back were approximately six inches away from the back of the seat. When queried regarding the position of the Resident's knees and their Range of Motion (ROM), RN G responded that both of Resident #51's knees were contracted and did not straighten. CNA S pushed Resident #51 into their room in the wheelchair and informed RN G they needed to get the lift (Hoyer -mechanical lift used to lift and transfer dependent individuals) and assistance to put Resident #51 in bed. When queried regarding Resident #51's lower extremity ROM, CNA S responded that the Resident's knees are always bent backwards (towards their buttocks) and do not straiten. CNA S exited the room at this time. Resident #51 continued to yell out continuously. RN G attempted to give Resident #51 their crushed medications in pudding via spoon, but the Resident clenched their teeth while continuing to make loud noises. Resident #51 was reaching their hand out and grabbed my hand. I began to sing Bell Bottom Trousers (Popular WW2 song from 1944/1945) and Resident #51 immediately stopped yelling out and took their medications. When I stopped singing, Resident #51 asked me to sing again. Upon exiting the room, Resident #51 was not yelling out. An interview was conducted with RN G after exiting Resident #51's room on 6/2/26 at 2:10 PM. When queried regarding how the Resident stopped yelling with singing and interventions, RN G stated, We did have a radio in there (Resident room) for a while but (Resident #51) started yelling over it. When queried if Resident #51 preferred a specific type of music or if they were yelling when certain music was played, RN G revealed they did not know. RN G verbalized Resident #51 seems to be calmer when they sit with them and talk to them. Review of Resident #51's Electronic Medical Record (EMR) revealed a Social Services care plan entitled, (Resident #51) has the potential for psychosocial distress related to: anticipated dementia progression, expressing sadness / anger / empty feeling over lost roles and status (Initiated and Revised: 12/18/24). The care plan included the interventions:- Family in to visit for socialization and support as able (Initiated: 12/18/24)- Identify behavioral precipitants, if possible, to assist with further defining effective dementia care and trauma informed care (Initiated: 12/18/24)- If behavioral, rule out pain, decrease stimulation (Initiated: 11/21/25)- Maintain a calm environment as able (Initiated: 12/18/24)- Acknowledge residents mood and behavior; conveying acceptance toward the resident while rejecting negative behavior (Initiated: 12/18/24)- Allow opportunities for expression of individuality which include: reading (Initiated: 12/18/24)- Behavior monitoring as identified on the individualized log; utilize log for patterning and intervention revision as indicated (Initiated: 12/18/24)- Evaluate changes in mood and socialization (Initiated: 12/18/24)- Behavior Meeting: 6/4/25, 1/8/26 (Initiated: 6/6/25; Revised: 1/8/26)- Behavior monitoring as identified on the individualized log; utilize log for patterning and intervention revision as indicated (Initiated: 12/18/24)- Evaluate changes in mood and socialization (Initiated: 12/18/24) Another care plan entitled, (Resident #51) has experienced a recent loss of spouse (Initiated and Revised: 4/22/26). The care plan included the interventions:- Explain the stages of grief related coping strategies, and grief work through each stage (Initiated: 4/22/26)- Explore with the resident previous effective and ineffective coping mechanisms (Initiated: 4/22/26)- Identify relationships for the resident to draw on (Initiated: 4/22/26)- Implementation of visual checks (insert frequency) for the purpose of: (Blank) (Initiated: 4/22/26)- Provide opportunities to listen and support communication of feelings (Initiated: 4/22/26)- Support grief reactions (Initiated: 4/22/26)- Treat primary mood disorder by: quite (sic) environment, soft music, redirection (Initiated and Revised: 4/22/26) Review of Resident #51's EMR revealed the Resident had documentation of agitation and yelling out beginning in 2025. Per (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Maple Woods Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 13137 North Clio Road Clio, MI 48420	
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation, Resident #51 was taking Prozac (antidepressant medication) daily when they were admitted . During their stay at the facility, Depakote (anticonvulsant medication used as a mood stabilizer) 250 milligrams (mg) three times a day (TID) was added in August 2025 due to increased mood swings and verbal behaviors associated with dementia, Ativan (anti-anxiety medication) TID was added in November 2025 due to agitation and yelling related to progressive dementia, and Tylenol with Codeine (Tylenol #3- narcotic pain medication) TID was added in May 2026 due to concerns of pain related to increased behaviors. Documentation in Resident #51's EMR detailed: - 3/10/26: Healthcare Provider Acute/Follow-Up. Progress Note.Chief Complaint. Agitation. seen today for reports of agitation. Plan: Agitation due to Dementia. - 4/9/26 at 2:47 PM: Interdisciplinary Documentation. Spoke with (Family Member V) r/t (related to) addition of Prozac (antidepressant medication) 20 mg (milligrams) daily r/t depressive disorder. (Family Member V) is in agreement with addition of medication - 4/24/26: Healthcare Provider Acute/Follow-Up. Progress Note. recently lost (spouse) who was in the facility as a resident. Although significant dementia, it is possible that (spouses) passing may be affecting (Resident) . Seen at nurses' station, up in wheelchair. Seems agitated. Yelling out. - 5/28/26: Physician Acute/Follow-Up. seen today for agitation. recently lost (spouse) who was in the facility as a resident. Although significant dementia, it is possible that (spouses) passing may be affecting (Resident) . Patient has been having some episodes of yelling out in the hallway and resistive to cares. Decision to place patient on T-3 (Tylenol #3- narcotic pain medication) to ensure relief from pain . - 5/28/26 at 10:21 AM Type: Interdisciplinary Documentation. Following behavioral health meeting, and recommendations from NP. Writer placed call to (Family Member V) to go over recommendations of scheduled Tylenol #3 . (Family Member V) in agreement with (Resident #51 showing signs of pain and started scheduled pain medication. An interview was completed with Social Worker (SW) O on 6/2/26 at 3:05 PM. When queried regarding Resident #51, SW O verbalized the Resident had dementia and had behavioral monitoring in place. When queried regarding the Resident yelling out and personalized, resident-centered interventions related to their dementia, SW O indicated they would need to review the care plan. SW O verbalized they did not want to make care plan interventions so specific that staff only did the interventions specified on the care plan. When asked if reading was an appropriate intervention for Resident #51, with their current cognitive level and progression of dementia, SW O did not provide a direct response and indicated they would need to review the Resident's information and provide follow up. On 6/2/26 at 4:23 PM, an interview was completed with the Director of Nursing (DON) and Clinical RN N. When queried regarding Resident #51 yelling in the hallway, the DON and RN N revealed they were aware of the behavior. The DON and RN N were informed of observation of Resident #51 yelling in the hallway for over 30 minutes, staff walking past without acknowledging the Resident, ineffectiveness of staff telling Resident #51 they were okay, and how the Resident stopped yelling when I sang to them. When asked about the lack of personalized interventions related to dementia care including personalized, the DON and RN N verbalized understanding and indicated they would review the Resident's EMR. The DON and RN N were then queried regarding observation of the Resident's lack of ROM and staff statement indicating their Bilateral Lower Extremities (BLE) were contracted, the DON confirmed the Resident did have impaired ROM in BLE. When asked about Resident #51's wheelchair positioning, including observation of their legs not being positioned on the footrests, the Resident's visible discomfort when their legs were moved to be positioned on the footrests as well as the space behind their back/buttocks, the DON and RN N responded they would have Therapy evaluate the Resident for positioning. The DON and RN N were asked if Resident #51 was able to verbalize if they were uncomfortable, they indicated the Resident was not. When queried why facility staff had not identified (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Resident's inability to articulate and verbalize discomfort and concerns with positioning and had the Resident evaluated by Therapy previously, an explanation was not provided. Upon request for the facilities dementia management and care policy/procedure, RN N responded that the facility does not have a policy/procedure pertaining to dementia management. Review of Resident #51's EMR revealed the Resident was not receiving restorative nursing services related to limited ROM. Review of Resident #51's Documentation Survey Report for May 2026 included a section titled Behavioral Care every shift (three shifts per day). Review of Behavioral Care documentation revealed 24 times with no (blank) documentation. Review of the documentation completed revealed the resident displayed behaviors a total of 12 times including crying three times, Disruptive sounds four times, Verbal Aggression/Swearing four times, and Negative Statements once. On 6/3/26 at 9:04 AM, an interview was completed with Clinical RN N regarding Resident #51. RN N revealed a Therapy Eval was ordered for Resident #51 related to wheelchair positioning and the therapy determined a Broda chair Broda chair (specialized, reclining and cushioned wheeled chair with solid leg rests used for individuals with limited mobility to provide advanced positioning and comfort) was more appropriate for the Resident. RN N further revealed the facility was going to have Activities do more person-centered activities with Resident #51. An interview was completed with a cognitively intact Resident (Resident #2) who resides in the same hall of the facility as Resident #51 on 6/3/26 at 10:06 AM. When queried regarding how they are treated by facility staff, Resident #2 responded they are able to take care of themselves and it is the people who can't that they worry about. When asked what they meant, Resident #2 stated, (Resident #51) yells out all the time and they do nothing for them. Just let them yell and scream. With further inquiry, Resident #2 revealed Resident #51 yells out during the day and the night in both the hallway and in their room. Resident #2 stated, You can tell (Resident #51) in pain, and they (staff) don't do nothing. When asked what they meant when they said the staff don't do anything, Resident #2 responded that facility staff either ignore Resident #51 or just tell them they will be alright which does not work. Resident #2 further revealed they chose to stay in their room with the door closed because of the yelling. On 6/3/26 at 11:00 AM, an interview was completed with RN G. When queried regarding Resident #51, RN G revealed Therapy had evaluated the Resident and recommended a Broda Chair. RN G stated, (Resident #51) looks so much more comfortable in the Broda. With further inquiry, RN G revealed the Resident had not been crying (yelling) out like they had been previously since being in the Broda chair. On 6/3/26 at 11:28 AM, Resident #51 was observed sitting in a Broda chair in their room with their eyes open. The Resident was slightly reclined, and their legs were slightly elevated. Resident #51 was not yelling out and appeared comfortable with no non-verbal signs/symptoms of distress and/or pain observed. When spoke to, Resident #51 made eye contact but did not provide meaningful responses to questions. An interview was conducted with the DON and RN N on 6/3/26 at 11:36 AM. When queried regarding Resident #51, the DON verbalized they spoke to Family Member Witness V and were updating the care plan with personalized interventions. When asked why the care plan had not been updated previously to include personalized interventions prior to identification during survey, an explanation was not provided. When queried why Resident #51 had not been evaluated for positioning previously, when increased pain was considered and scheduled pain medication was implemented, a response was not provided. The DON and RN N were informed of observation of Resident #51 in the Broda Chair and staff statements of decreased behaviors. Resident #51's lack of assessment, evaluation, and implementation of individualized care interventions directed towards understanding and relieving the Resident's distress to promote physical and psychosocial comfort and wellbeing with dementia diagnosis were discussed with the DON and RN N. The DON and RN N verbalized understanding of the (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern but did not provide further explanation. An interview was completed with Physical Therapy Staff W on 6/3/26 at 2:32 PM. When queried who had evaluated Resident #51 for positioning needs, Therapy Staff W replied, OT (Occupational Therapy) evalued them. When queried if it would be possible to review the OT note pertaining to Resident #51's evaluation, Therapy Staff W reviewed the Resident's Therapy documentation and stated that the OT did not complete their note. A review of the Resident's therapy EMR with Therapy Staff W revealed the OT note was opened but no clinical documentation related to positioning needs and evaluation had been documented. A follow-up interview was completed with SW O on 6/3/26 at 12:57 PM. When queried if they had reviewed Resident #51's EMR, SW O indicated they had and stated, We added some things in the care plan and one-on-one (activities) in the care plan. When queried if the reason for Resident #51 yelling out continuously was related lack of understanding the Resident's dementia, SW O replied, Yeah, for sure. SW O then stated, The DON talked to (Family Member V) and (Resident #51) really likes gospel music. SW O verbalized they went to see Resident #51 today and they were interacting with the gospel music and not yelling out. Review of Resident #51's EMR revealed the DON authored the following note on 6/3/26 at 10:09 AM, Interdisciplinary Documentation. (Family Member V) was contacted today to discuss (Resident #51's) preferences and hobbies to provide more effective comfort measures. (Family Member V) shared that (Resident #51) responded positively to her providing a hug and sharing pictures of her grandkids. (Family Member V) also noted that attempting to provide that same intervention with random videos/pictures of children laughing/playing that (Resident #51) did not respond in the same manner. (Family Member V) noted that (Resident #51) often enjoyed old TV westerns such as [NAME] and Lone Ranger but is no longer able to watch them as the action within these shows now causes distress. Other noted hobbies/activities [NAME] used to enjoy were quilting, sewing, knitting, and scrapbooking, but (Family Member V) provided the observation that [NAME] is no longer capable of carrying out these activities. (Family Member V) stated that she too had noticed the increase in behaviors such as moaning/shaking/mumbling and believes these are related to both the recent passing of (Resident #51's spouse) and her research of 'Dementia crying'. This writer discussed with (Family Member V) offering to have (Resident) up out of bed later in the evening on days where (they are) available for visit. Review of facility provided policy/procedure entitled, Care Planning Process: Admission, Comprehensive & Short Term (Revised: 11/2017) revealed, Policy. It is the policy of this facility to utilize the results of the MDS assessment to develop, review, and revise resident care plans. To ensure prompt assessment and delivery high standard Person-Centered Care and to communicate resident needs. The facility did not have a policy/procedure pertaining to Dementia care and/or management.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication administration error rate of less than 5% when three medication errors were observed for two residents (#19 and #104) from a total of 25 observations, resulting in a medication error rate of 12%. Findings include: Resident #104: A medication pass observation was completed with Licensed Practical Nurse (LPN) F for Resident #104 on 6/3/26 at 7:35 AM. LPN F indicated Resident #104 wanted their Voltaren 1% (topical pain relief medication) gel and would need to obtain the medication from the medication room where it was kept. LPN F entered the medication room and after looking in the drawers, verbalized the Voltaren gel was not there. When asked what they were going to do, LPN F revealed they would let the Resident know they did not have it. Upon entering Resident #104's room, the Resident had their knee brace down waiting for application of the Voltaren gel and LPN F told them their Voltaren gel was not available. The Voltaren gel was not administered and omitted. Resident #19: On 6/3/26 at 7:47 AM, a medication pass observation for Resident #19 was completed with LPN F. LPN F removed a Humalog insulin KwikPen 100 units/milliliter (mL) pen (insulin pen for treatment of diabetes mellitus) from the medication cart for Resident #19, attaching the needle, and turned the dial to select 5 units for administration. LPN F did not prime the insulin pen. LPN F then sat the pen down directly on top of the medication cart. LPN F proceeded to remove all of Resident #19's oral medications in the prepacked pharmacy medication packets from the medication cart, as well as a Norco 5 milligram (mg)/325 mg (narcotic pain medication) tablet, crushed all the medications together, and mixed with pudding. One of the medications LPN F had removed from the medication cart and crushed was mirabegron 25 mg Extended-Release 24-hour (extended-release medication used to treat overactive bladder). When asked why they crushed the Resident's medications, LPN F responded that the Resident prefers to have their medications crushed and they are always crushed. LPN F then closed the medication cart and verbalized they were ready to administer the medications. Prior to administering the medications to Resident #19, LPN F was stopped and asked extended-release medications should be crushed. LPN F responded that extended-release medications are generally not crushed. When asked why they had crushed an extended-release medication for administration to Resident #19, LPN F revealed they were unsure which medication was extended release. Resident #19's Medication Administration Record (MAR) was reviewed, and LPN F confirmed the Resident's mirabegron 25 mg was an extended-release medication and should not be crushed. After disposing of the crushed medications, LPN F prepared the oral medications again and proceeded to go to Resident #19's room with their medications including the insulin pen at 8:24 AM. LPN F was stopped prior to administration again and asked if they had primed the insulin pen. LPN F responded they had not and stated they thought the pen only needed to be primed when it was used for the first time. LPN F proceeded to prime the pen with the current needle on it, dispose of the current needle, and put a new needle on the pen without priming it. LPN F administered the insulin pen in Resident #19's right upper arm. LPN F held the dose injector knob down for two seconds and then held the pen in place for seven additional seconds without holding the dose injector knob down. An interview was completed with LPN F immediately after exiting Resident #19's room. When queried why they primed the insulin pen, disposed that needle, and then put on a new needle but did not prime it, LPN F did not provide an explanation. When queried why they only held the dose injector knob down for two seconds, LPN F revealed they were unsure how long they had held it down but knew the pen had to be held in place. No further explanation was provided. An interview was completed with the Director of Nursing (DON) and Clinical Support Registered Nurse (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(RN) N on 6/3/26 at 8:55 AM. When queried if extended-release medications should be crushed, both the DON and RN N responded they should not. When asked if insulin pens should be primed prior to administration, the DON and RN N both verbalized they should. After being informed of identified concerns during the medication pass observation for Resident #'s 104 and 19 with LPN F, the DON and RN N verbalized understanding. Review of facility policy/procedure entitled, Medication Administration by the Various Routes (Revised: December 2024) revealed, It is the policy of this facility to administer medication in agreement with standards of practice.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were competent to sign a binding arbitration agreement prior to the resident signing it for one resident (Resident #36) of 3 residents reviewed for arbitration agreements and a Confidential Group of 10 Residents who were aware of the meaning of an arbitration agreement from a census of 104 residents. Findings Include: Arbitration A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #36 was admitted to the facility on [DATE] with diagnoses: Non-traumatic brain dysfunction, Alzheimer's disease, diabetes, heart disease, hypothyroidism, anxiety, depression and arthritis. The admission MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 6/15. On 6/1/2026 at 9:25 AM during the Entrance Conference with the Administrator, she was asked if the facility used Arbitration agreements and she stated, Yes, we do. A list of residents who signed the document indicating they wanted arbitration was requested. On 6/2/2026 at 2:05 PM, the Administrator provided a list of resident who signed Arbitration agreements in the facility. There were 44 of 104 residents that signed they wanted it. Upon review of arbitration agreements for 3 residents including Resident #36, it revealed the resident signed the document on 5/4/2026. Upon further review of the Medical record for Resident #36, it identified a document titled, Physician Determination of Decision Making Capability. The document was signed by two medical providers. The facility Medical Director A signed the document on 5/4/2026 indicating, As the resident's attending physician, I am making a medical determination that the above named resident is no longer capable of understanding the Bill of Rights and participating in Medical Treatment Decisions. On 5/13/2026 an additional medical provider signed the document indicating the resident was no longer capable of making medical treatment decisions. On 6/02/2026 at 3:05 PM, admission Director B was interviewed about the facility's arbitration agreements. She said she reviewed them with the resident or their representative by the next day after admission or Monday if admission was on a Friday. When asked how she determined if a resident was able to make a competent decision to sign the document, as indicating they would want arbitration, she said if they had a Power of Attorney/POA she would contact that person or if they sounded confused she would ask a Nurse or Social Worker. During the interview with the admission Director B on 6/2/2026 at 3:05 PM, the arbitration agreement that Resident #36 signed was reviewed. She said the resident had signed the document. Reviewed (continued on next page)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the Admissions Director that the resident's physician had determined she was not capable of making medical decisions on the same day 5/4/2026. The Admissions Director B said she was not aware of that. On 6/3/2026 at 3:25 PM, the Administrator was asked about residents signing the arbitration agreements when they were not able to make their own decisions and she said the facility was looking into that. A review of the facility policy titled, Voluntary Binding Arbitration Agreement, date effective August, 2024 provided, Policy: It is the policy of this facility to present the Voluntary Binding Arbitration Agreement (VBAA) to Resident/Resident's Legally Authorized Representative (Representative) after the admission paperwork is completed. The policy did not mention assessment of the residents' competence prior to signing the document. In interviews on 06/02/2026 at 1:00 PM in the East dining room with confidential residents, the state surveyor inquired if residents were familiar with the arbitration agreements. 10 of 10 residents that attended the meeting did not know what the arbitration agreement was, or if they had signed an arbitration agreement. The surveyor stated that grievances with the facility are discussed and the resident and facility reach a resolution by mutual agreement without the use of the legal system.		