STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235526	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Park Terrace	14676 West Upright Charlevoix, MI 49720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the right to be free from verbal abuse by staff for one Resident (#6) of three residents reviewed for abuse. Findings include: This citation pertains to intake: 2667693Resident #6 (R6)Review of the Electronic Medical Record (EMR) for R6 revealed admission to the facility on 9/1/25 with diagnosis of cerebral infarction. R6 scored an 8/15 on a Brief Interview for Mental Status (BIMS) score dated 9/5/25, indicating moderate cognitive impairment. However, the medical record indicated R6 was responsible for their own medical and financial decisions.An interview was conducted with Social Services Director (SSD) M on 11/20/25 at 1:30 p.m. SSD M stated she was walking down the B hall when Registered Nurse (RN) G stated, Do I prevent a fall or let someone get the [explicit word] beat out of them. SSD M then proceeded down the hallway to grab RN B to assist. SSD M stated she started to hear loud and aggressive shouting and when coming through the doors in the B hall, witnessed RN G in close proximity of R6 stating Because your CNA (Certified Nurse Aide) was busy getting the [explicit word] beat out of her. SSD M stated RN B attempted to diffuse the situation between RN G and R6, but indicated RN G continued to be aggressive in the hallway. SSD M stated they separated RN G and R6 and proceeded to call the Nursing Home Administrator (NHA).An interview was conducted with RN B on 11/20/25 at 1:46 p.m. RN B stated she was assisting a resident with behaviors approximately four rooms down from the incident with R6 and RN G. RN B stated she heard loud voices coming from the hallway and when stepping out to see what was happening, saw RN G inches from the face of R6 and was yelling It's because your CNA was busy getting the [explicit word] beat out of her, that's why! RN B stated RN G's voice was aggressive and angry. RN B stated she went toward R6 to comfort her and R6 stated, I have a hard time hearing and then she yelled at me. When RN B tried to diffuse the situation and separate R6 and RN G away from each other, RN G stated, It's not ok, no one really understands it's really not ok. RN B confirmed she helped report the incident to the NHA.Camera footage was reviewed with the NHA on 11/20/25 at 2:20 p.m. Registered Nurse (RN) G and R6 were observed on camera, in the hallway and RN G was with R6 crouching down, with her finger pointed at R6 and coming within inches of R6's face. RN G was observed standing up and turning around, before quickly turning back to R6 still sitting in the hallway and getting very close to R6's face again. Two staff members come into the hallway with one approaching R6 while RN G goes off camera.An interview was conducted with R6 on 11/20/25 at 2:45 p.m. R6 stated she has a very difficult time hearing but does not need staff to yell at her for her to understand.Review of the facility's Abuse Prevention Program read, in part, Our residents have the right to be free from abuse.as part of the resident abuse prevention, the administration will: Implement measures to address factors that may lead to abusive situations.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the residents right to be free of misappropriation of property by staff. This deficient practice resulted in psychosocial harm based on the reasonable person perspective. Findings include: This citation pertains to intake: 2615537Resident #5 (R5)Review of R5's Electronic Medical Record (EMR) revealed admission to the facility on 7/2/25 and discharge on [DATE]. Review of R5's medical diagnosis included metabolic encephalopathy (brain dysfunction caused by chemical imbalance).On 8/30/25, Family Member N was visiting R5 who was actively dying at the facility and stayed until approximately 3:30 a.m. Family Member N noted during the visit, R5 had her gold wedding band and solitaire diamond band on her fingers. Family Member N returned to the facility at approximately 12:00 p.m. on 8/30/25 and continued to sit with R5 until her death at 12:45 p.m. Family Member N requested R5's rings be given to him before she was taken to the funeral home. It was at this time Family Member N and staff noted the rings were missing from R5's fingers. Family Member N reported this to the floor nurse and Nursing Home Administrator (NHA) and a search was conducted. Local police were contacted and had begun an investigation into whether R5's missing wedding rings were misappropriated.On 8/31/25, Licensed Practical Nurse (LPN) O spoke to Family Member N and stated one of R5's wedding rings had been recovered when Certified Nurse Aide (CNA) I returned the ring after being questioned by police in connection to the investigation.An interview was conducted with Registered Nurse (RN) P on 11/21/25 at 12:00 p.m. RN P confirmed one missing ring was returned by CNA I after being questioned by police. RN P stated CNA I was only in R5's room for approximately a minute before exiting with one ring. CNA I stated she found the ring stuck in the wheel of R5's bed. RN P stated only one ring was retrieved of two that were missing.An interview with Detective Q on 11/21/25 at 10:50 a.m. confirmed local police were involved in the alleged misappropriation of R5's wedding rings. Detective Q stated, upon investigation, CNA I admitted to the misappropriation of the wedding rings and was arrested on the morning of 8/30/25.An interview was conducted with CNA I who confirmed she did steal R5's rings on 8/30/25 after Family Member N had left the facility. CNA I confirmed she did try and plant one of R5's rings in her room after an investigation had begun.An interview was conducted with the NHA on 11/21/25 at 2:00 p.m. The NHA stated that Family Member N requested R5's wedding rings continue to stay on her finger while staying at the facility. NHA stated that Family Member N recognized that R5 would be devastated if her wedding rings were not there. Review of the facility's ?Abuse Prevention Program' policy read, in part, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.

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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 ensure a physician-prescribed bowel protocol was followed for two Residents (#3 & #7) of three residents reviewed for quality of care. Findings include:This citation pertains to intake number #2641745. Resident #3 (R3)Review of complaint intake number #2641745 submitted to the State Agency (SA), on 10/13/25 revealed R3 has had a diagnosis of hemorrhoids. The Complainant stated R3 went for days without having a bowel movement in the facility and they were concerned with the bowel management care being provided. Review of R3's face sheet revealed an admission to the facility on 7/24/25 with diagnoses including hemorrhoids, hypothyroidism, diabetes mellitus, and hypertension. Review of a quarterly Minimum Data Set (MDS) assessment, dated 10/27/25, revealed R3 was dependent on staff for activities of daily living cares including toileting, shower/bathing, lower body dressing, and putting on/taking off footwear. R3's brief interview for mental status (BIMS) revealed moderate cognitive impairment. The Physician's orders for R3 revealed the following order for bowel protocol: a. Day 2 - 4 oz. (ounces) prune juice or apple juice,b. Day 3 - GI (gastrointestinal) assessment, offer 4 oz. prune/apple juice and 17 g (grams) [brand name laxative] polyethylene glycol or 10 mg (milligrams) bisacodyl tabs, c. Day 4 - GI assessment, 10 mg [brand name laxative] bisacodyl suppository, if refuses offer 4 oz. prune or apple juice and 17 g [brand name laxative] polyethylene glycol or 10 mg bisacodyl tabs, d. Day 5 - GI assessment, notify physician and follow doctor's orders post assessment,e. Day 6 - GI assessment, notify physician and follow doctor's orders post assessment.On 11/21/25 at 11:30 AM, an interview was conducted with Family Member L who was asked about R3's bowel movements and replied, It is an ongoing problem. She (R3) is still not getting the polyethylene glycol I was giving her at home to help her move her bowels and with her hemorrhoids it just makes it worse. Review of R3's bowel movements revealed the following:R3 went two days without having a bowel movement on the following days 10/10/25, 10/17/25, 10/25/25, 11/6/25, 11/10/25, and 11/14/25. No documentation was seen for interventions to administer prune or apple juice 4 oz. to R3.R3 went three days without having a bowel movement on 11/7/25 and 11/15/25. No documentation of a GI assessment was completed. No intervention was documented to show R3 was given any of the following interventions: offer 4 oz. prune/apple juice and 17 g polyethylene glycol or 10 mg bisacodyl tabs. R3 went four days without having a bowel movement on 11/16/25 with no documented GI assessment. No interventions were documented to show R3 was given any of the following interventions: 10 mg bisacodyl suppository, if refuses offer 4 oz. prune or apple juice and 17 g polyethylene glycol or 10 mg bisacodyl tabs. Review of R3's progress notes and electronic medication administration dated 10/23/25 through 11/21/25 revealed no documentation of interventions or GI assessments related to bowel protocol. Review of R3's care plan, dated 11/21/25 revealed no care plan related to R3's diagnosis of hemorrhoids, constipation, or bowel management. Resident #7 (R7)Review of R7's face sheet revealed an admission to the facility on 7/30/24 with diagnoses including constipation, heart failure, diabetes mellitus, and hypertension. Review of R7's quarterly MDS assessment dated [DATE] revealed R7 required substantial maximal assistance from staff for activities of daily living cares including toileting, shower/bathing, upper/lower body dressing, and putting on/taking off footwear. R7's BIMS revealed moderate cognitive impairment. Review of R7's bowel movements revealed the following:R7 went two days without having a bowel movement on 10/7/25, 10/10/25, 11/3/25, 11/8/25, 11/14/25, and 11/18/25. No documentation was seen showing R7 was administered 4 oz. of prune or apple juice.R7 went three days without having a bowel movement on 10/11/25, 11/4/25 and 11/15/25. No documented GI assessment was present in the medical record. No documentation was seen showing R7 was offered 4 oz. of prune/apple juice and 17 g polyethylene glycol or 10 mg bisacodyl tabs. Review of R7's progress notes and electronic medication administration dated 10/23/25 through 11/21/25 revealed no documentation of interventions or GI assessments related to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bowel protocol. On 11/21/25 at 10:00 AM, an interview was conducted with the Director of Nursing (DON), who was asked what their expectations were for nursing to follow through with bowel protocol and replied, Well if a resident does not have a bowel movement on days 2 through 6 then they should be following the bowel protocol depending on which day the resident is on for not having a bowel movement. The DON was asked if nursing was following bowel protocol where they should be documenting an intervention and replied, Nurses should be documenting on the medication administration record or in the progress notes. The DON confirmed that both R3 and R7 had lacked expected documentation showing nurses had been following bowel protocol. The DON agreed intervention not documented were considered not done. The DON was asked for a bowel management policy and replied, The facility does not have a policy on bowel management. Nursing is to follow bowel protocol.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Findings include: Resident #7 (R7)Review of R7's face sheet revealed an admission to the facility on 7/30/24, with diagnoses including constipation, heart failure, diabetes mellitus, and hypertension (elevated blood pressure). Review of R7's quarterly Minimum Data Set (MDS) assessment, dated 10/17/25, revealed R7 required substantial maximal assistance from staff for activities of daily living cares including toileting, shower/bathing, upper/lower body dressing, and putting on/taking off footwear. R7's brief interview for mental status (BIMS) revealed moderate cognitive impairment. Section M Skin revealed R7 had a facility acquired stage II pressure ulcer (an open sore on the skin that involves partial-thickness loss of dermis) that was unhealed, and indicated R7 was at risk for developing additional pressure ulcers.On 11/20/25 at 10:30 AM, an interview was conducted with R7 in his room. R7 was lying in bed and resting. R7 was asked about having a pressure ulcer on his buttock and replied, Yes, I do. R7 was observed lying on his left side with a wedge placed under the right side of his back. R7 was observed laying on a regular pressure reduction mattress and no air mattress overlay was observed. During the interview with R7, his roommate (Resident #3) stated staff were not in at all the previous night (referring to 11/19/25) to turn and reposition R7, and stated R7 never had an air mattress on the bed. Resident #3's BIMS was obtained from a current MDS and indicated intact cognition. On 11/20/25 at 11:15 AM, an observation was made of R7 during a wound dressing change for his sacral area and surrounding buttocks. R7 was observed displaying signs and symptoms of excruciating pain during the dressing change procedure including hyperventilating and moaning. R7 called out, I just want it to be done. Ouch! Oh God! and repeated this during much of the dressing change. During the wound dressing change, Registered Nurse (RN) D was assisted by Certified Nurse Aide (CNA) J who helped position R7 up on his left side and held him there. RN D who was performing the dressing change stated, He's (R7) in pain. Poor guy is in pain. RN D was asked to measure the wounds and classify them and stated there was one large unstageable pressure ulcer (a full thickness tissue loss where the damage is obscured by slough - yellow, tan, gray, green, or brown dead tissue or eschar) and three other smaller stage II pressure ulcers that were facility acquired. RN D was asked to measure R7's current wounds which were found to be as follows:a. Pressure ulcer unstageable to the coccyx, facility acquired, and measured 10 centimeters (cm) in length x 7 cm in width x 0.6 cm (depth),b. Pressure ulcer stage II to the right buttock, facility acquired, and measured 3 cm in length x 1.5 cm in width, no depth,c. Pressure ulcer stage II to the upper left buttock, facility acquired and measured 1.2 cm in length x 1.0 cm in width. No depth,d. Pressure ulcer stage II to the lower left buttock, facility acquired and measured 3 cm in length x 3.5 cm. in width. No depth. R7's progress note, dated 11/20/25 at 12:22 PM, read in part, New order for resident to go to ED to have his ulcerations on his buttocks looked per [local surgeons group name] . R7's progress note, dated 11/20/25 at 12:44 PM, read in part, Resident left the facility via EMS [emergency medical services] approximately 1240 (12:40 PM) . Review of R7's hospital records, dated 11/20/25 through 11/24/25, revealed the following:a. History and physical 11/20/25, chief complaint: decubitus ulcer [pressure ulcer]. Assessment and plan: 1. Infected decubitus ulcer - large unstageable chronic decubitus ulcer at the coccyx, surrounding erythema [redness], drainage, appears infected. 2. Sepsis. 3. Elevated lactic acid level [a build-up of lactic acid in the bloodstream commonly caused by sepsis]. 4. Hyponatremia [decreased sodium in the bloodstream]. 5. Hyperglycemia [elevated blood glucose]. 6. Urinary retention. 7. Diastolic heart failure (ineffective pumping of blood from the heart to the body to meet its needs).b. Consultation report 11/22/25, reason for consultation: bacteremia (infection in the blood stream by bacteria). Assessment and plan: Gram positive bacteremia, MSSA [methicillin susceptible staphylococcus aureus] infection, decub [decubitus] ulcer, leukocytosis [elevated white blood cells], transient bacteremia likely related to his wound which had not been debrided (removed damaged tissue) at that point. Wound is deep with exposed bone. Minimum 2 week IV [intravenous] course though may extend longer depending on the appearance of wound. Discussed with hospitalist, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	in order to heal the wound patient would need IV antibiotic in addition to off-loading, aggressive wound care, enteral feeding, potential diverting ostomy [a surgical created opening on the abdomen, called a stoma, that allows waste products like stool to exit the body]. c. Hospital course 11/20/25 through 11/24/25 and ongoing: positive blood culture, positive wound infection culture, two different antibiotics, wound debridement, and two different IV strong opioid (drug derived from opium and strong pain reliever) pain medications.d. Wound description and measurements post-surgical debridement 11/21/25: Assessment and plan 1. Decubitus ulcer, sepsis with staph aureus bacteremia. Status post incision and drainage - Surgical findings: The black eschar [a layer of dead, dry, and dark tissue that forms over a wound] that was visible measured initially 4.0 x 4/2 cm with surrounding stage II decubitus for a total size of 10.5 x 10.5 cm. The initial black eschar was lifted and debrided resulting in the wound being 5.2 x 4/2 cm. Unfortunately, it then tunnels 5 cm cephalad [toward the head] (4 cm wide) under viable skin. The total amount of the cavity debrided measured approximately 5.2 cm wide extending a total of 10 cm between the open tunneled area. This was debrieded [sic] with sharp dissection, cautery [a hot instrument to burn and seal blood vessels], pulse lavage [washing out], and then deampened (sic) gauze with quarter percent Dakin's (diluted bleach solution used as an antiseptic to clean and disinfect ulcers). During an interview on 11/20/25 at 1:15 PM, RN D was asked how long R7 had the pressure ulcers and replied, It has been over a couple months, but I am not exactly sure when it developed. RN D stated R7 was being sent to the local hospital for a general surgery consult for the pressure ulcer today after dressing change and working on the wound clinic this week. On 11/20/25 at 1:30 PM, an interview was conducted with RN B who was asked if R7 had an infection in their pressure ulcer and how often wounds were to be measured and replied, I do not recall him being on the line listing [prescribed antibiotics/monitoring infection]. Wounds are to be measured every Sunday.On 11/20/25 at 2:40 PM, an interview was conducted with the Director of Nursing (DON) who was asked about interventions for R7 and their pressure ulcer and replied, Air mattress and turning and repositioning every two hours. The DON was asked why R7 did not have an air mattress prior to today on his bed and replied, I am not sure, but he should have had one.On 11/21/25 at 2:45 PM, an interview was conducted with CNA H who was asked if R7 had an air mattress on their bed prior to today and replied, No, I don't think so. It just came over the walkie talkie to go ahead and put it on a little while ago. Review of R7's wound management detail report, dated 5/3/25 through 11/20/25, revealed the following:a. Date identified 5/3/25 Wound type: Other, Stage I, wound location: coccyx, measurement 23 cm x 30 cm, wound healing status: stable, comments: Cleaned left buttock wounds and coccyx wound with Saf-Clens. Dried and covered wounds with Sacral Mepilex. (4x4 Mepilex unavailable).b. Date observation 7/26/25 Wound type: Other, Stage I, wound location: coccyx, measurement 23 cm x 30 cm, wound healing status: stable, comments: Removed Mepilex, petroleum jelly dressing and cleaned the area with wound cleanser. Applied petroleum jelly dressing and covered with Mepilex.c. Date observation 11/17/25 Wound type: Other, Stage I, wound location: coccyx, measurement 4 cm x 4 cm, wound healing status: declining, comments: Unstageable with black eschar and foul odor noted. Review of R7's wound management detail report, dated 6/8/25 through 11/20/25, revealed the following:a. Date identified 6/8/25 Wound type: Pressure ulcer, wound location: left buttock, measurement 1cm x 1.75 cm, can depth be measured: yes, 0.2 cm, exudate amount: light, exudate color and consistency: serous (clear, amber, thin and watery), wound odor present: no, stage: stage II, tissue type: granulation, skin surrounding wound: dark purple or rusty discoloration, comments: Medi-honey with Mepilex ordered.b. Date observation 7/26/25 Wound type: Pressure ulcer, wound location: left buttock, measurement 1cm x 1.75 cm, can depth be measured: no, exudate amount: light, exudate color and consistency: bloody (bright red, thin), tissue type: granulation tissue, wound healing status: improving, comments: Removed Mepilex, petroleum jelly dressing and cleaned the area with wound cleanser. Applied petroleum jelly dressing and covered with Mepilex.No weekly wound measurements were found in R7's electronic medical record. Review of R7's quarterly Braden scale (residents at risk for (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	developing pressure ulcers), dated 5/15/25, revealed R7 was at risk for developing pressure ulcers. No other quarterly Braden scale was found for the next quarter month of September 2025. On 11/21/25 at 11:00 AM, an interview was conducted with the DON, who was asked how R7 was doing and if there were any updates from the local hospital and replied, [R7] was having some debridement today. The DON was asked why R7's wounds were not measured weekly and replied, They should have been completed weekly.Review of R7's care plan, dated 10/23/25, read in part, Problem: Category: Pressure Ulcer/Injury; Alteration in skin integrity R/T (related to) areas of pressure on buttocks.Potential for further pressure ulcer development.Unstageable pressure injury to coccyx. Goal: Unstageable pressure injury to coccyx will heal without complications by target date. Approach: Treatments as ordered 11/20/25. Enhanced barrier precautions. Treatments per order. See MAR.Encourage food and fluid intake at mealtimes.Low air loss pressure mattress to bed 11/12/24. The low air loss pressure mattress was implemented and was not in use at the time of the first observation of R7. The facility implemented the low air loss pressure mattress during the survey after R7 had already went to the hospital. The wounds progressed from stage II pressure injuries to unstageable pressure injuries which subsequently had to be debrided at the hospital. There was marked deterioration of the wounds observed in the documentation from 11/17/25 to 11/20/25 as described below:R7's progress notes revealed the following:5/6/25 at 4:43 PM, read in part Skin on coccyx is noted to be intact but red.6/8/25 at 4:32 PM, read in part Called into resident's room by CNA. Noted to have an open area on the middle of the L buttock that measures 1.0 cm x 1.75 cm x 0.2 cm. Noted to have a pink base and noted to have irregular wound edge.7/13/25, read in part Resident was found to have two open areas on left buttock. The medial sore measured 0.5cmx0.5cm and the lateral sore measured 0.75cmx0.5cm.7/20/25 at 12:58 PM, read two open areas to left natal cleft the medial one is 0.4cm x 0.4cm x <0.1 the 2nd is lateral to the first and is 0.5cm x 0.5cm x <0.1, wound bases are pink wound edges are not adhered and surrounding skin is normal for skin color.9/22/25 at 6:52 PM, read in part Resident's continues to have bilat (bilateral) upper buttocks wounds that are beefy red and tender when cleaned/palpated.11/17/25 at 2:18 PM, read in part This writer was notified by the assigned nurse that [R7's] decubitus wounds over his coccyx has progressed. This writer noted two unstageable decubitus with eschar and a foul odor.11/17/25 at 2:40 PM, read in part .After discussing.it was determined to contact surgical services for recommendaiton (sic) and likely planned ED visit.11/19/25 at 2:13 PM, read in part .Completed dressing change- base of the wound is noted to be black and does have a foul odor.11/20/25 at 12:00 PM, read in part Completed dressing change on his buttock- Removed old dressing, noted to have an odorus (sic) smell, and base of the wound is noted to be dark in color on the sacral area. Does (sic) have two small open areas on the upper and lower portion of the wound. Does have an irregular shape. The middle open area measures 10 cm x 8 cm x 1.2 cm. The open area on the R (right) lower portion of the wound measures 3 cm x 4 cm x <0.1 cm. There is an open area on the L (left) upper portion of the wound that measures 2 cm x 3 cm x <0.1 cm. Applied crushed Flagyl to the wound bed, packed the large wound in the middle, covered with Hydrogel soaked 4x4 guaze (sic), and covered with an abdominal pad.11/20/25 at 4:21 PM, read in part Update recieved [sic] from.local ER [emergency room].admitted d/t (due to) decubitus ulcer on his buttock. Surgery is seeing him tomorrow. Will probably mostly end up with a wound vac and IV (intravenous) anx (antibiotic) therapy.Noted to have hyperglycemia, increased lactic acid, and hyponatremia (low sodium). WBC (white blood cell count) 16.8 [elevated].Review of policy titled, Pressure Ulcer/Skin Breakdown - Clinical Protocol, dated June 2023, read in part, Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcer; for example, immobility, recent weight loss, and history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate pain control was achieved for one Resident (Resident #7) of three residents reviewed for pain management. This deficient practice resulted in Resident #7 experiencing excruciating uncontrolled pain during pressure ulcer dressing changes.Findings include: Resident #7 (R7)Review of R7's face sheet revealed an admission to the facility on 7/30/24 with diagnoses including constipation, heart failure, diabetes mellitus, and hypertension. Review of R7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R7 required substantial maximal assistance from staff for activities of daily living cares including toileting, shower/bathing, upper/lower body dressing, and putting on/taking off footwear. R7's Brief Interview for Mental Status (BIMS) revealed moderate cognitive impairment. section M of the MDS revealed R7 had a stage II describe stage 2 pressure ulcer. A review of the Physician's Orders for R7 on 11/20/25, revealed no pain medication was provided to R7 until 11/17/25. The first dose of Tramadol 50 mg (milligrams) was provided at approximately 2:00 PM, and continued to be scheduled every six hours at 2:00 AM, 8:00 AM, 2:00 PM, and 8:00 PM. R7's medication administration record dated 11/1/25 through 11/20/25 revealed on 11/17/25 at 8:00 PM the drug was not administered because it was documented unavailable.Review of R7's pain assessments, dated 5/1/25 through 11/20/25, revealed no documented pain assessments after 10/17/25 by nursing. Review of R7's progress note, dated 9/22/25 at 6:52 PM, read in part, Resident's (sic) continues to have bilat (bilateral) upper buttocks wounds that are beefy red and tender when cleaned/palpated.NP (nurse practitioner) stated she is to do orders after assessing wounds with his nurse.According to the facilities MDS matrix (form 802 census and conditions), dated 11/20/25, R7 had a facility acquired pressure ulcer that was describe as an unstageable pressure injury. Review of R7's care plan, dated 11/20/25, revealed no care plan with interventions related to pain management. On 11/20/25 at 10:30 AM, an interview was conducted with R7 in his room. R7 was lying in bed and resting. R7 was asked about having a pressure ulcer on his buttock and replied, Yes, I do. R7 was noted to be lying on his left side with a wedge placed under his right back, and a regular bed mattress and not an air mattress.On 11/20/25 at 11:15 AM, an observation was made of R7 during a wound dressing change on his sacral area and surrounding buttocks. R7 was observed in excruciating pain and was visualized hyperventilating and moaning. R7 called out, I just want it to be done. Ouch! Oh God! and repeated this during much of the dressing change. During the wound dressing change Registered Nurse (RN) D was assisted by Certified Nurse Aide (CNA) J who helped position R7 up on his left side and held him there. RN D did not offer R7 any additional analgesia for the pain. During the wound dressing change, Registered Nurse (RN) D stated, He's (R7) in pain. Poor guy is in pain. RN D was asked to measure the wounds and classify them and stated that there was one large unstageable and three other smaller stage II pressure ulcers that were facility acquired.During an interview on 11/20/25 at 11:35 AM, an interview was conducted with CNA J who was asked how long R7 was having increased pain with dressing changes and replied, Over the last month he (R7) has been having a lot more pain. I told several staff that his pain was worse, and nothing was done. He has been having a lot more pain because of his bottom. This past week has been extremely hard on him. Review of facility standing orders, dated 12/17/2024, revealed standing orders for pain/discomfort included administration of acetaminophen either oral or rectal q (every) 4 hours prn (as needed). The standing orders also stated if pain is persistent or not completely relieved, notify Dr (doctor) on rounds sheet, and if the pain is severe with little or no relief, nursing was to perform a head-to-toe assessment and notify Dr. None of this was documented completed for R7. On 11/21/25 at 12:30 PM, an interview was conducted with RN F who was asked how long R7 was experiencing pain during wound dressing changes and replied, For a month and it has become worse in the last week or two. During an interview on 11/21/25 at 12:45 PM with the Director of Nursing (DON) who (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235526	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Park Terrace	14676 West Upright Charlevoix, MI 49720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	was asked about pain assessments for R7 and why nursing was not completing the pain assessments over the last month when staff verbalized that R7's pain was present during wound dressing changes and increased extensively over the last week. The DON stated, Pain assessments should be completed each shift. There should be an order in place for nursing to complete a pain assessment. I am not sure why there is not an order to do so. If he (R7) was having pain, then nursing should have at least been giving acetaminophen from the standing orders and if that did not help then the provider should have been contacted related to pain during dressing changes. The DON agreed that a premedication prior to dressing changes would be beneficial for R7.Review of policy titled, Pain Assessment and Management, date revised March 2015, read in part, Purpose: Support consistent pain assessment and documentation and promote safe treatment and follow up. General Guidelines.2. Complete a pain assessment each shift for any resident with pain.3. Use the o to 10 subjective pain scale for residents who self-report.6. Document all findings.Responsibilities: Nurse 1. Complete all pain assessments.6. Notify the provider of uncontrolled pain.8. Reassess after interventions. 9. Update the care plan when needed.