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	06/05/2025

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 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 prior to the administration of psychotropic medications for two Residents (#16 and #36) of five residents reviewed for unnecessary medications. Findings include: Resident #16 (R16) Review of the Minimum Data Set (MDS) assessment, dated 4/16/2025, revealed R16 was admitted to the facility on [DATE] and had diagnoses including traumatic brain injury, bipolar disease, restlessness and agitation. Further review of the MDS assessment revealed R16 had moderate cognitive impairment. Review of R16's physician orders revealed an active order for Haldol (an antipsychotic medication used to stabilize mood, behaviors and thoughts) 1 milligram (mg) and 2 mg tablets by mouth daily. The order was dated 11/30/2023. Review of R16's electronic medical record (EMR) revealed no acknowledgement of informed consent (education regarding the need for the medication and the risks, benefits and alternatives) signed by R16 or their representative for the administration of the oral Haldol. During an interview on 6/4/2025 at 2:00 p.m., Social Services Designee, Staff I, was asked about the process for obtaining informed consent for psychotropic medication use. Staff I reported the providers and nursing staff were responsible for obtaining informed consent prior to treatment being initiated. Staff I reported she audited the EMR on a regular basis for use of psychotropic medications, including checking for informed consent. Staff I was asked to provided information pertaining to informed consent prior to administration of oral Haldol for R16. At 2:25 p.m., Staff I reported no information related to informed consent was found. Resident #36 (R36) Review of the MDS assessment, dated 1/19/2025, revealed R36 was admitted to the facility on [DATE] and had diagnoses including anxiety. Further review of the MDS assessment revealed R36 was cognitively intact. Review of R36's physician orders revealed an active order for Xanax (a controlled, antianxiety medication) 0. 5 mg tablet by mouth PRN (as needed) daily for Other specified anxiety disorders. The order was dated 5/28/2025 and had an end date of 6/28/2025. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R36's EMR revealed no informed consent for the use of the PRN Xanax. During an interview on 6/5/2025 at 8:43 a.m., the Director of Nursing (DON) reported nursing staff were responsible for ensuring informed consent was obtained prior to the initiation of psychotropic medications. The DON reported he would check R16 and R36's EMR's for the missing documentation. At 2:05 p.m., the DON confirmed there were no consents obtained for R36's PRN Xanax or R16's oral Haldol. Review of the facility policy titled, Antipsychotic Medication Use, last revised 3/2015, revealed the following: The physician shall respond appropriately by changing or stopping problematic doses or medications or clearly documenting (based on assessing the situation) why benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. It was noted the policy did not include information related to informing residents or their representatives of the specific need for the medication or the risks, benefits and adverse effects related to administration of antipsychotic medications. Review of the facility policy titled, Medication Management, with a reviewed date of 9/9/2022, revealed the following: A resident and/or representative has the right to be informed about the resident's condition; treatment options, relative risks, and benefits of treatment, required monitoring, expected outcomes of treatment; and has the right to refuse care and treatment.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility presented a list of residents whose Medicare Part A Service had ended and were eligible to receive a SNF ABN (a document to alert of payment changes). Three Residents (R37, R41 and R56) on this list were chosen and their medical records were requested to assure proper notification had been delivered. The medical record form: SNF Beneficiary Notification Review was received for R37, R41 and R56 and each read, Was a SNF ABN, From CMS-10055 (Center for Medicare and Medicaid Services) provided to the resident? Each form had No checked and continued, If no, explain why the form was not provided. Each had a handwritten explanation which read, Change in BO (Business Office) Staff. During an interview on 6/5/25 at 12:50 PM, the Nursing Home Administrator (NHA) stated there had been a recent change in office personnel within the last month. The NHA said, The new girl in the office has been educated on the proper form to use. We have not been using the right CMS form. The form 10055 was not used. The NHA agreed the facility failed to provide the most up-to-date SNF ABN Notice detailing estimated charges of continued services to all residents discharging from Medicare Part A Services over the past year. This citation pertains to intake MI00152335. Based on interview and record review, the facility failed to provide notice of a change in coverage and/or billed services for four Residents (#35, #37, #41 and #56) of four resident reviewed. Findings include: Resident #35 (R35) Review of the Minimum Data Set (MDS) assessment, dated 3/1/2025, revealed R35 was admitted to the facility on [DATE] and indicated R35 was cognitively intact. During an interview on 6/3/2025 at 7:43 p.m., R35 expressed frustration at the facility billing process. R35 reported the amount due on his monthly statement from the facility had increased over the past six months and he was not notified prior to the increase. During an interview on 6/5/2022 at 10:22 a.m., the Admissions/Business Office Coordinator, Staff R reported the facility had not increased the amount it charged for services in the past 12 months. Staff R reported she was aware of R35's concerns regarding the amount he owed the facility and confirmed the amount of R35's amount due on a monthly basis had increased due to his insurance coverage changing. During a review of R35's record with Staff R it was noted the facility received notice of changes to R35's Medicaid coverage which included a change in the Resident's Medicaid patient payment amount. Staff R reported the patient payment amount was the amount of the monthly fee Medicaid required the Resident to pay the facility each month to maintain Medicaid eligibility. Further review of R35's record for November 2024 through May 2025 revealed changes to Medicaid coverage on the following dates: On 11/01/2024 R35's patient pay amount increased from $1,414/month to $1,589/month. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/01/2025 R35's patient pay amount increase from $1,589/month to $1,631/month. On 4/01/2025 R35's patient pay amount decreased from $1,631/month to $1,621/month. During the interview, Staff R was queried to the process of alerting residents of changes to the amount owed to the facility. Staff R stated a written notice is not provided by the facility to inform the residents when the facility is notified of changes in coverage that effect the amount billed monthly. Staff R confirmed R35 was not informed by the facility of the change in Medicaid coverage and patient payment amounts as referenced previously. Staff R reported being unaware of the requirement to provide such notifications as she believed Medicaid provided R35 with the same notification the facility received and assumed R35 would understand the monthly amount he was personally liable for had changed. During an interview on 6/5/2025 at 10:51 a.m., the Nursing Home Administration (NHA) reported the facility had multiple conversations and attempts at explaining the increase in billing to R35 in relation to the Medicaid patient payment amount. When asked if the explanation had been as soon as the facility was alerted by Medicaid and prior to the changes to the amount the Resident was liable for or in response to R35 voicing concerns after he received his statements showing the changes. The NHA reported she was unsure what had prompted the conversations with R35 regarding his payment to the facility. The NHA reported the Business Office staff were responsible for sending billing and coverage notifications when warranted.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a homelike environment by serving residents their meals on institutional trays in the resident dining rooms. Findings include: On 6/4/25 at approximately 8:00 AM, the breakfast meal was observed being served to residents in the main dining areas. Staff served the residents their breakfast meal with plates, cups and tableware on service trays. On 6/4/25 at 12:00 PM, the lunch trays were set up in the kitchen with items on a tray for each resident. The staff then served the meal to each resident in the dining room) without removing the items from the trays. On 6/04/25 at 4:20 PM, residents were asked about their thoughts regarding the meal service and if it was like when they were living at home. Resident #40 (R40) whose electronic medical record (EMR) contained a Brief Interview for Mental Status assessment (BIMS) dated 3/26/25 of 11 out of 15 (indicating moderate cognitive impairment) shook her head no. She said she did not eat meals on a tray. R32 whose EMR contained a BIMS assessment dated [DATE] of 15 out of 15 (indicating cognitively intact) agreed that was not how she ate her meals when she was at home. R32 stated, It is easier for the staff (to keep the meals on the tray). R48 stated again, That is not how I ate my meals at home. On 6/5/25 at 7:54 AM, the breakfast meal was observed in the rehabilitation unit dining room. Residents were eating their meal as served on the institutional trays. Plates and beverages were not removed for a homelike status. During an interview on 6/05/25 at 8:10 AM, the Certified Dietary Manager (CDM) Q stated she would like the staff to remove the items off the trays, but they do not always do this. .

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F 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake M00153232 Based on interview and record review, the facility failed to monitor and prevent resident to resident sexual abuse for two Residents (#14 and #40) of four residents reviewed for abuse. This deficient practice resulted in feelings of being violated, humiliation, anxiety. Findings include: Review of a facility five-day investigation summary, submitted to the State Agency (SA) on 5/23/25 at 8:54 a.m., revealed the following: On 5/19/25 (Resident #40 [R40]) groped (Resident #14 [R14's]) breast at 8:58 the incident occurred. Staff witnessed (R14) slapping her hand on (R40's) shoulder repeatedly. When asked why (R14) was doing that and they were pulled apart, (R14) stated he squished my breast. I just wanted him to stop so I was hitting him . R14 Review of the Minimum Data Set (MDS) assessment, dated 5/15/25, revealed R14 was admitted to the facility on [DATE] with active diagnoses that included Alzheimer's Disease, anxiety, and depression. R14 scored a 3 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. R40 Review of the MDS assessment, dated 5/15/25, revealed R40 was admitted to the facility on [DATE]. R40 scored a 3 of 15 on the BIMS assessment reflective of severe cognitive impairment. Further review of the Electronic Medical Record (EMR) revealed R40 had a diagnosis of dementia. Further review of the MDS assessment Section E Behavioral Symptoms: revealed R40 experiences physical behavioral symptoms directed toward others i.e. Hitting, kicking, pushing, scratching, grabbing, abusing others sexually every 4 to 6 days. During an interview on 6/5/25 at 8:25 a.m., Nursing Home Administrator (NHA) reported, I printed off pictures for you and you can see where he reached out to her, he touched her and then she slapped him away. Review of facility pictures on 6/5/25 at 8:32 a.m., revealed R40 sitting in his wheelchair with his hand on her blouse grabbing her breast. During an interview on 6/5/25 at 9:50 a.m., Family Member (FM) L stated I would say my mom felt very violated and upset over this happening to her .My mom would not have liked that and would have resisted. FM L reported the staff called me shortly after it happened, and she pushed away from him and swatted out to him. She was upset about it .the staff sat with her and calmed her down. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of witness statement on 5/19/25 Registered Nurse (RN) N reported Per resident, [R14] told this writer the other resident squished her breast . showing with her hand demonstrating a squishing or cupping gesture. Review of witness statement dated 5/19/25 Certified Nurse's Aide (CNA) O reported I was walking down the hall to the front of A hall by the lobby. As I approached the lobby [Licensed Practical Nurse (LPN) P] was pulling [R40's] wheelchair back in the lobby. [LPN P] stated [R14] was hitting [R40]. When I approached [R14] told me, he grabbed my boob. I just wanted him to stop so I was hitting him . Review of witness statement on 5/19/25 LPN P reported I heard commotion in the bird area while standing at the med cart. [R14] was sitting in a chair and [R40] was sitting in his wheelchair next to her. [R14] was using her right hand and repeatedly making contact (hitting [R40's] shoulder . During an interview on 6/5/25 at 11:59 a.m., the NHA acknowledged that sexual abuse had occurred. Review of facility policy titled Abuse Prevention Program read in part, .Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document specific behaviors, signs and symptoms of anxiety targeted by the administration of a PRN (as needed) antianxiety medication for one Resident (#36) of five residents reviewed for unnecessary medications. Findings include: Resident #36 (R36) Review of the MDS assessment, dated 1/19/2025, revealed R36 was admitted to the facility on [DATE] and had diagnoses including anxiety. Further review of the MDS assessment revealed R36 was cognitively intact. Review of R36's physician orders revealed an active order for Xanax (a controlled, antianxiety medication) 0. 5 mg tablet by mouth PRN daily for Other specified anxiety disorders. The order was dated 5/28/2025 and had an end date of 6/28/2025. Review of R36's EMR, including physician progress notes for May and June 2025, no documented rationale related to the administration of the medication for more than a 14-day timeframe. Review of R36's May and June 2025 Medication Administration Records (MAR's), revealed the PRN Xanax 0.5 mg was administered on 5/28/2025 at 5:25 p.m. The documentation listed on the MAR revealed the reason for administration as, generalized, not feeling well. R36's EMR revealed no documentation of specific behaviors, signs or symptoms of anxiety targeted by the administration of the PRN Xanax 0.5 mg tablet on 5/28/2025. No documentation was found regarding the use of non-pharmacological interventions prior to administration of the PRN medication. During an interview on 6/5/2025 at 8:43 a.m., the Director of Nursing (DON) reported nursing staff were responsible to document the use of non-pharmacological interventions attempted and failed prior to the administration of PRN psychotropic medications. The DON reported he would check R36's EMR for the missing documentation. At 2:05 p.m., the DON confirmed there was no documentation of the specific need or use of non-pharmacological interventions related to the administration of PRN Xanax on 5/28/2025 for R36. Review of the facility policy titled, Medication Management, with a review date of 9/9/2022, revealed the following: The nursing care center established monitoring guidelines for managing medications to promote their safety and effective use and to prevent potential adverse consequences . non-pharmacological interventions such as behavior modification and social services and their effects are documented as a part of the care planning process and are utilized by the prescriber in assessing the continued need for medication.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure allegations of abuse were identified and reported to the State Agency (SA) for three Residents (#40, #49 and #22) of four residents reviewed for abuse. Findings include: Resident #49 (R49) Review of the Minimum Data Set (MDS) assessment, dated 4/15/2025, revealed R49 was admitted to the facility on [DATE] and had diagnoses including left ankle fracture, anxiety and schizophrenia. Further review of the MDS assessment revealed R49 was cognitively intact and had no behaviors of psychosis including hallucinations or delusions. Review of R49's electronic medical record (EMR) revealed the following progress note: 05/22/2025 12:53 PM Administrator was told a male resident was just in her room, he rolled in by wheelchair. Administrator went down to see the room and set up [sic] and apologize. Male resident had put his hand on [R49's] bed, under her cover to the left of her leg area. NP (Nurse Practitioner) in building notified, male resident's guardian notified and [R49's] guardian notified. Ensured [R49] felt safe in her room at this time. Stop sign already installed but noted not in use, applied to doorway when writer exited room. On 6/4/25 at 4:24 p.m., R49 was observed lying in bed with her left foot elevated on a pillow. R49 reported she recently underwent a surgical intervention to treat a left ankle fracture she obtained in a fall. R49 reported she was unable to ambulate unassisted and required use of a lift and staff assistance for transfers. R49 was asked if she had ever encountered another resident entering her room uninvited to which she stated, a man in a wheelchair came in and put his hand under my blanket and touched my leg. I didn't know him. I held his hand tight to stop him because he was trying to go up my leg. R49 was observed motioning to her left upper thigh and reported the incident made her feel uncomfortable. R49 reported the male resident gave up and then wheeled his chair over to her roommate, Resident #22's (R22's) bed and reached under R22's blanket, at which time R49 yelled for help and staff came in to remove the male resident from the room. R49 reported she alerted the nurse responding that Resident #40 (R40) reached under her blanket and attempted to run his hand up her thigh. R22 Review of the MDS assessment, dated 3/27/2025, revealed R22 was admitted to the facility on [DATE] and had diagnoses including major depressive disorder, quadriplegia (paralysis of all four limbs) and Alzheimer's Disease. Further review of the MDS assessment revealed R22 had severe cognitive impairment and was dependent of staff for ADL's (Activities of Daily Living), transfers and mobility. On 6/4/2025 at 4:30 p.m., R22 was observed lying in bed. R22 presented as pleasantly confused and was unable to answer questions related to the allegation of R40 reaching under her blanket and touching her as reported by R49. Review of R22's EMR revealed the following progress note: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/22/2025 12:59 PM Administrator was told a male resident was just in her room, he rolled in by wheelchair. Administrator went down to see the room and set up [sic] and apologize. Male resident had put his hand on [R22's] bed, under her cover to the left of her leg area. NP in building notified, male resident's guardian notified and [R22's] guardian notified. Ensured [R22] felt safe in her room at this time. Stop sign already installed but noted not in use, applied to doorway when writer exited room. R40 Review of the MDS assessment, dated 2/20/2025, revealed R40 was admitted to the facility on [DATE] and had diagnoses including dementia. The MDS assessment revealed R40 had severe cognitive impairment, required supervision for ambulation and was independent for wheelchair mobility. Review of R40's care plan revealed the following: Problem Start Date: 2/27/2025. Category: Behavioral Symptoms: Resident has physical behavioral symptoms toward others (e.g., hitting, kicking, pushing, scratching, abusing others sexually). Approaches: 5/10/2025, Monitor resident's location when up in [wheelchair], direct away from female residents. Review of a progress note, signed by the Nursing Home Administrator (NHA) and dated 5/22/2025 at 1:05 p. m., revealed the following: Administrator was told a male resident was just in female room, he rolled by wheelchair. Administrator went down to see the room and set up [sic] and apologize. Male resident had put his hand on both of their beds . NP in building notified, [R40's] daughter notified . Further review of R40's EMR for May 2025 revealed the following documentation prior to 5/22/2025: 5/05/2025, 9:25 a.m., [R40] has had some unacceptable behaviors in running his hands across the bottoms of female staff members . 5/07/2025, 6:23 p.m., resident has been sexually inappropriate this shift toward aide. He stated during care, Do you like what you see? and proceeded to try to grab nurse aide inappropriately. 5/08/2025, 5:59 p.m., He had another episode of running his hand across my buttocks earlier in shift . 5/10/2025, 2:00 p.m., Resident was sexually inappropriate with staff during toileting time. 5/10/2025, 3:29 p.m., Resident was in hallway and may have come into physical contact with another female resident . Resident will be kept away from other residents for his and others safety. 5/14/2025, 12:26 p.m., Resident was sexual with staff during toileting time. Grabbing at her vaginal area and saying, you want this because you like it. 5/19/2025, 11:38 a.m., We are investigating [R40] touching another resident on her chest. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/20/2025, 2:52 p.m., resident attempted to touch nurse aide inappropriately. 5/21/2025, 10:53 a.m., Resident forcefully grabbing CNA [Certified Nursing Assistant] in bathroom during toileting . 5/22/2025, 10:59 a.m., Resident slapped staff on bottom . On 6/5/2025 at 12:00 p.m., a review of the SA database revealed the allegation of abuse occurring on 5/22/2025 and involving R40, R49 and R22 was not submitted for review by the facility. During an interview on 6/5/2025 at 12:14 p.m., the NHA was asked regarding the incident on 5/22/2025 involving R40, R49 and R22. The NHA reported she was aware of the incident. When asked why the incident was not reported to the SA as an allegation of abuse, the NHA stated, because there was no physical contact. The NHA reported R40 only reported, R40 was in room and reaching under her blanket. When asked if she was aware that R40's roommate, R49 had also reported being touched by R40 on the same occasion, the NHA stated she was unaware. When asked if she was concerned about R40's intentions due to the Resident's history of inappropriate sexual touch of female resident's and staff, the NHA replied, Absolutely. The NHA was alerted to R40 and R49's report to this Surveyor of R40 placing his hand on her thigh in a sexual manner and of her report R40 did the same to R49. The NHA replied, that's not what she said to me. During an interview on 6/5/2025 at 2:58 p.m., Registered Nurse (RN) B reported she was caring for R40 and R49 on 5/22/2025 and recalled the incident in which R40 was found in the female resident's room. When asked to recall the event, RN B reported R40 was calling out for help and she (RN B) and Occupational Therapist (OT) M entered the room to find R40 with is hand under R22's blanket touching the Resident's leg. RN B reported R22's roommate (R49) reported R40 had also reached under her blanket and touched her leg but after she (R49) pushed R40's hand off her thigh, he moved over to R22's bed reached under her blanket by her left leg. RN B confirmed the event was reported to the NHA. On 6/5/2025 at 3:12 p.m., OT M reported he recalled entering R49 and R22's room on 5/22/2025 with RN B after hearing R49 calling for help. OT M reported he did not witness R40 touching either resident as he quickly left the room to alert the NHA for assistance in redirecting R40. Review of the facility policy titled, Abuse Prevention Program, last revised 12/2026, revealed the following: As part of the resident abuse prevention, the administration will . Investigate and report any allegations of abuse within timeframes as required by federal requirements.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure allegations of abuse were thoroughly investigated for three Residents (#40, #49 and #22) of four residents reviewed for abuse. Findings include: Resident #49 (R49) Review of the Minimum Data Set (MDS) assessment, dated 4/15/2025, revealed R49 was admitted to the facility on [DATE] and had diagnoses including left ankle fracture, anxiety and schizophrenia. Further review of the MDS assessment revealed R49 was cognitively intact and had no behaviors of psychosis including hallucinations or delusions. Review of R49's electronic medical record (EMR) revealed the following progress note: 05/22/2025 12:53 PM Administrator was told a male resident was just in her room, he rolled in by wheelchair. Administrator went down to see the room and set up [sic] and apologize. Male resident had put his hand on [R49's] bed, under her cover to the left of her leg area. NP in building notified, male resident's guardian notified and [R49's] guardian notified. Ensured [R49] felt safe in her room at this time. Stop sign already installed but noted not in use, applied to doorway when writer exited room. On 6/4/25 at 4:24 p.m., R49 was observed lying in bed with her left foot elevated on a pillow. R49 reported she recently underwent a surgical intervention to treat a left ankle fracture she obtained in a fall. R49 reported she was unable to ambulate unassisted and required use of a lift and staff assistance for transfers. R49 was asked if she had ever encountered another resident entering her room uninvited to which she stated, a man in a wheelchair came in and put his hand under my blanket and touched my leg. I didn't know him. I held his hand tight to stop him because he was trying to go up my leg. R49 was observed motioning to her left upper thigh and reported the incident made her feel uncomfortable. R49 reported the male resident gave up and then wheeled his chair over to her roommate's, Resident #22's (R22's) bed and reached under R22's blanket at which time R49 yelled for help and staff came in to remove the male resident from the room. R49 reported she alerted the nurse responding that Resident #40 (R40) reached under her blanket and attempted to run his hand up her thigh. R22 Review of the MDS assessment, dated 3/27/2025, revealed R22 was admitted to the facility on [DATE] and had diagnoses including major depressive disorder, quadriplegia (paralysis of all four limbs) and Alzheimer's Disease. Further review of the MDS assessment revealed R22 had severe cognitive impairment and was dependent of staff for ADL's (Activities of Daily Living), transfers and mobility. On 6/04/2025 at 4:30 p.m., R22 was observed lying in bed. R22 presented as pleasantly confused and was unable to answer questions related to the allegation of R40 reaching under her blanket and touching her as reported by R49. Review of R22's EMR revealed the following progress note: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/22/2025 12:59 PM Administrator was told a male resident was just in her room, he rolled in by wheelchair. Administrator went down to see the room and set up [sic] and apologize. Male resident had put his hand on [R22's] bed, under her cover to the left of her leg area. NP in building notified, male resident's guardian notified and [R22's] guardian notified. Ensured [R22] felt safe in her room at this time. Stop sign already installed but noted not in use, applied to doorway when writer exited room. R40 Review of the MDS assessment, dated 2/20/2025, revealed R40 was admitted to the facility on [DATE] and had diagnoses including dementia. Further review of the MDS assessment revealed R40 had severe cognitive impairment, required supervision for ambulation and was independent for wheelchair mobility. Review of R40's care plan revealed the following: Problem Start Date: 2/27/2025. Category: Behavioral Symptoms: Resident has physical behavioral symptoms toward others (e.g., hitting, kicking, pushing, scratching, abusing others sexually). Approaches: 5/10/2025, Monitor resident's location when up in [wheelchair], direct away from female residents. Review of a progress note, signed by the Nursing Home Administrator (NHA) and dated 5/22/2025 at 1:05 p. m., revealed the following: Administrator was told a male resident was just in female room, he rolled by wheelchair. Administrator went down to see the room and set up [sic] and apologize. Male resident had put his hand on both of their beds . NP in building notified, [R40's] daughter notified . Further review of R40's EMR for May 2025 revealed the following: 5/05/2025, 9:25 a.m., [R40] has had some unacceptable behaviors in running his hands across the bottoms of female staff members . 5/07/2025, 6:23 p.m., resident has been sexually inappropriate this shift toward aide. He stated during care, Do you like what you see? and proceeded to try to grab nurse aide inappropriately. 5/08/2025, 5:59 p.m., He had another episode of running his hand across my buttocks earlier in shift . 5/10/2025, 2:00 p.m., Resident was sexually inappropriate with staff during toileting time. 5/10/2025, 3:29 p.m., Resident was in hallway and ay have come into physical contact with another female resident . Resident will be kept away from other residents for his and others safety. 5/14/2025, 12:26 p.m., Resident was sexual with staff during toileting time. Grabbing at her vaginal area and saying, you want this because you like it. 5/19/2025, 11:38 a.m., We are investigating [R40] touching another resident on her chest. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/20/2025, 2:52 p.m., resident attempted to touch nurse aide inappropriately. 5/21/2025, 10:53 a.m., Resident forcefully grabbing CNA [Certified Nursing Assistant] in bathroom during toileting . 5/22/2025, 10:59 a.m., Resident slapped staff on bottom . During an interview on 6/5/2025 at 12:14 p.m., the NHA was queried regarding the incident on 5/22/2025 involving R40, R49 and R22. The NHA reported she was aware of the incident. When asked if she was concerned about R40's intentions due to the Resident's history of inappropriate sexual touch of female resident's and staff, the NHA replied, Absolutely. The NHA was asked to provide the incident report and investigation conducted related to the event. The NHA reported an investigation into the incident was not conducted. During an interview on 6/5/2025 at 2:58 p.m., Registered Nurse (RN) B reported she was caring for R40 and R49 on 5/22/2025 and recalled the incident in which R40 was found in the female resident's room. When asked to recall the event, RN B reported R40 was calling out for help and she (RN B) and Occupational Therapist (OT) M entered the room to find R40 with is hand under R22's blanket touching the Resident's leg. RN B reported R22's roommate (R49) reported R40 had also reached under her blanket and touched her leg but after R49 pushed R40's hand off her thigh, he moved over to R22's bed and reached under her blanket by her left leg. RN B confirmed the event was reported to the NHA. On 6/5/2025 at 3:12 p.m., OT M reported he recalled entering R49 and R22's room on 5/22/2025 with RN B after hearing R49 calling for help. OT M reported he did not witness R40 touching either resident as he quickly left the room to alert the NHA for assistance in redirecting R40. Review of the facility policy titled, Abuse Prevention Program, last revised 12/2026, revealed the following: As part of the resident abuse prevention, the administration will . Investigate and report any allegations of abuse within timeframes as required by federal requirements.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #258 (R258) Review of an admission Record revealed R258 was originally admitted to the facility on [DATE]. On 6/4/25 at 9:33 AM., R258 was observed on a stretcher being wheeled out via ambulance/paramedics. On 6/4/25 at 9:35 AM, Certified Nurse Aide (CNA) C was interviewed and reported R258 was not feeling well this morning, and reported this to the nurse, and a decision was made to send R258 out to the Emergency Department (ED). Review of R258's Electronic Medical Record EMR revealed. 6/04/2025 05:32 PM Late Entry- Resident observed to be confused/difficult to arouse/complaining of feeling cold. Weak. Altered mental status Call placed to EMS (Emergency Medical Services) to transport to Hospital for evaluation NP notified/ DON (Director of Nursing) notified . Resident sent out at approx 0930. - Resident is being admitted . Nursing (documented by RN B) On 6/5/25 at 3:05 PM., RN B was interviewed and reported R258 was admitted to the hospital yesterday. When asked if a bed hold policy was given to R258, RN B reported she did not give R258 a bed holds when she went out to the emergency room/hospital yesterday. RN B reported it was so busy yesterday; she didn't even get to do her charting until later in the day. Resident #263 (R263) Review of an admission Record revealed R263 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for R263 with a reference date of 5/9/25 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated R263 #12 was cognitively intact. Review of R263's progress notes revealed: 5/14/2025 12:35 PM Per (Nurse Practitioner-name omitted) believes that patient has the cardinal signs of Appendicitis. Requesting for patient to be sent out to the ED (Emergency Department) at this time . Review of R263's progress notes revealed: 4/2025 01:50 PM Resident left the facility via EMS (Emergency Medical Services) approximately 1245 . Review of R263's progress notes/and other documentation and notice of transfer to the ombudsman revealed R263 did not receive a bed hold policy, nor did the ombudsman receive a notice of transfer. Review of a facility Policy with a revision date of 3/2017 revealed: Bed-Holds and Returns .Policy Statement Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Policy Interpretation and Implementation 1. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents may return to and resume residence in the facility after hospitalization or therapeutic leave as outlined in this policy. 2. The current bed-hold and return policy established by the state will apply to Medicaid residents in the facility. 3. Upon admission and if practicable prior to transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the stale bed-hold period (Medicaid residents); and d. The details of the transfer (per the Notice of Transfer). 1. Medicaid residents who exceed the state's bed hold limit and/or non-Medicaid residents who request a bed-hold are responsible for the facility's basic per diem rate while his or her bed is held . Based on interview and record review, the facility failed to: - provide written information on the facility's bed hold policy, - provide written transfer notifications to the resident, and resident's representative, and; - (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide written record of transfer to the Office of the State Long-Term Care Ombudsman, as indicated in four Residents (#355, #36, #258, & #263) of four residents reviewed for facility initiated discharges. Findings include: Resident #355 (R355) The electronic medical record (EMR) for R355 revealed a transfer to the hospital on 4/4/25. The medical record did not indicate a written notification of transfer. There was no documentation of the facility bed hold policy being given to R355 or sent to the resident's representative. Resident #36 (R36) Review of R36's EMR for 1/1/2025 through 6/3/2025 revealed the Resident was emergently transferred out of the facility to an acute care hospital on 1/6/2025 and 2/21/2025. Review of the scanned documents section of the EMR revealed no written notification of transfer for the dates referenced. The EMR revealed no indication R36 or the Resident's representative was provided with written notification of transfer or that they were provided with the facility's bed hold policy.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure that required assessments were completed timely for four Residents (#4, #14, #42 and #44) out of 16 Residents reviewed for MDS (Minimum Data Set) assessments. Findings include: Resident #4 (R4) A review of R4's electronic medical record (EMR) revealed R4 had expired on [DATE]. The Minimum Data Set (MDS) assessment for [DATE] related to Death in Facility was noted as In process and had not been completed as of [DATE]. Resident #14 (R14) A review of R14's MDS assessment record revealed assessments were completed on [DATE], and [DATE]. The quarterly assessment after [DATE] was over 120 days old and had not been completed until [DATE] Resident #42 (R42) A review of R42's MDS assessment record revealed assessments were completed on [DATE], [DATE], and [DATE]. The quarterly assessment after [DATE] was over 120 days old and had not been completed until [DATE]. Resident #44 (R44) A review of R44's MDS assessment record revealed assessments were completed on [DATE], [DATE], and [DATE]. The quarterly assessment after [DATE] was over 120 days old and had not been completed until [DATE]. During an interview on [DATE] at 10:23 AM, Registered Nurse (RN) T reviewed the above MDS medical records. RN T stated she and a team of three nurses completed the facility MDS assessments. RN T reviewed R4's record and said, The death in facility has not been closed, or signed or submitted (per regulation). RN T also said at the beginning of May, the MDS team noticed that several resident assessments were late and had been missed in April. Those residents (R14, R42 and R44) were then scheduled and completed after the 120 days had expired. RN T stated that while the team was aware of the three residents who had been missed in April of 2025, they were unaware that the record for R4 had not been processed. During an interview on [DATE] at 10:40 AM, the Nursing Home Administrator (NHA) was not aware the required MDS assessments as listed above had not been completed in a timely manner. .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Level II PASARR (Preadmission Screening and Record Review) evaluation was completed on 1 of 1 sampled resident (Resident #41) with known serious mental illness. Findings include: Resident #41 (R41) A review of R41's electronic record indicated R41 was admitted to the facility with diagnosis including bipolar disorder on 2/28/25. R41's EMR indicated a PASARR hospital exemption discharge date d 1/30/25. The PASARR hospital exemption discharge noted R41 was being admitted to facility after a hospital stay where R41 required nursing facility services for their condition they received hospital care for and likely to require less than 30 days of nursing facility services. Therefore, a PASARR II assessment would not be initiated at that time. The PASARR hospital exemption discharge also stated, if that plan changes, please notify the OBRA (Omnibus Budget Reconciliation Act) Office as soon as possible for appropriate follow-up. On 6/4/25 1:45 PM while conducting an interview with the MDS (Minimum Data Set) nurse, a current PASARR was requested for R41's most recent admission on [DATE]. The MDS nurse stated that R41 had been in and out of the facility several times, with the last admission R41 became a long-term resident, requiring a PASARR II to be performed as R41 would be in the facility longer than 30 days. During a follow up interview with the MDS nurse on 6/5/25 at 8:27 AM, the MDS nurse stated they put in a PASARR request on 6/4/25 for R41 due to a change in condition. The MDS nurse stated R41 needed to have a PASARR II completed, so that is why the change in condition request was made, even though R41 had no change in condition. The MDS nurse stated that they were not the staff that typically did the PASARR requests, but had been delegated to request the PASARR, as the MDS nurse had the credentials to do it. The MDS nurse stated their understanding was that the facility's social services director was only a designee and could not fill out the paperwork requesting a PASARR. The MDS nurse stated they were trying to stay on top of the process for PASARR needs, but R41 had fallen through the cracks. The MDS nurse stated the facility did not have R41's PASARR II.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate baseline care planning regarding high risks focus areas for two Residents (#256 & #263) of 13 residents reviewed for baseline care planning. This deficient practice resulted in the potential for choking, complications from infections as well as overall unmet medical needs. Findings include: Resident #256 (R256) Review of an admission Record revealed R256, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Parkinson's, and dysphasia (difficulty swallowing). Review of the Minimum Data Set (MDS) 5-day admission assessment for R256, with a reference date of 5/31/25- revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated R256 was cognitively impaired. Review of R256's Care Plans revealed no Baseline Care Plan was in place for R256's focus area of difficulty swallowing and associated high risk of choking. Resident #263 (R263) Review of an admission Record revealed R263 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Enterococcus bacteremia (blood stream infection). Review of the MDS assessment for R263 with a reference date of 5/9/25 revealed a BIMS score of 12/15 which indicated R263 was cognitively intact. Review of R263's physicians orders revealed: penicillin G pot (potassium) in dextrose (antibiotics) piggyback; 3 million unit/50 mL (milliliters); intravenous (via PICC [peripherally inserted central catheter] line) Other Test: Once A Day IV (intravenous) PCN (penicillin) G 24 million Units every 24 hours continuous infusion. [Diagnosis: Bacteremia] .(start date) 05/07/2025 (end date) 06/09/2025 . In an interview on 6/5/25 at 3:05 PM., RN B reported R263 receives his antibiotic medication via a PICC line. (peripherally inserted central catheter, a long, thin, flexible tube inserted into a vein in the upper arm, typically just above the elbow). RN B reported any resident with a PICC line or IV medications are at risk for complications and infections. Review of R263's Care Plans revealed no Baseline Care Plan was in place for R263's focus area of his PICC line. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/5/25 at 3:34 PM., RN/MDS T reported R256 should have a baseline care plan focus in place for high risk for choking. RN/MDS T reported R263 should also have had a comprehensive care plan in place which included a focus areas for his PICC line. RN/MDS T reported the PICC line puts R263 at high risk for complications and infections. Review of a facility Policy with a revision date of 4/2009 revealed: Policy Statement Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Policy Interpretation and Implementation 1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem. 2. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly. 3. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: a. Are resident oriented; b. Are behaviorally stated; c. Are measurable; and d. Contain timetables to meet the resident's needs in accordance with the comprehensive assessment. 4. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. 5. Goals and objectives are reviewed and/revised a. When there has been a significant change in the resident's condition; b. When the desired outcome has not; been achieved; c. When the resident has been readmitted to the facility from a hospital/ rehabilitation stay; and or revised: d. At least quarterly. 6. The resident has the right to refuse to participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #263 (R263) Review of an admission Record revealed R263 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Enterococcus bacteremia (blood stream infection). Review of a Minimum Data Set (MDS) assessment for R263 with a reference date of 5/9/25 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated R263 was cognitively intact. Review of R263's medical record revealed no Comprehensive Care Plan was completed. Review of R263's physicians orders revealed: penicillin G pot (potassium) in dextrose (antibiotics) piggyback; 3 million unit/50 mL (milliliters); intravenous (via PICC [peripherally inserted central catheter] line) Other Test: Once A Day IV (intravenous) PCN (penicillin) G 24 million Units every 24 hours continuous infusion. [Diagnosis: Bacteremia] .(start date) 05/07/2025 (end date) 06/09/2025 . In an interview on 6/5/25 at 3:05 PM., RN B reported R263 receives his antibiotic medication via a PICC line. RN B reported any resident with a PICC line or IV medications are at risk for complications and infections. In an interview on 6/5/25 at 3:34 PM., RN/MDS T reported R263 should have had a comprehensive care plan in place which included a focus areas for his PICC line. Based on interview and record review, the facility failed to develop comprehensive, person-centered care plans for two Residents (#49 and #263) of 16 resident reviewed. Findings include: Resident #49 (R49) Review of the Minimum Data Set (MDS) assessment, dated 4/15/2025, revealed R49 was admitted to the facility on [DATE] and had diagnoses including left ankle fracture, anxiety and schizophrenia. Review of the MDS Section J - Health Conditions, revealed R49 almost constantly experienced pain and was receiving scheduled and PRN (as needed) pain medication. The MDS assessment revealed R49 was cognitively intact and had no behaviors of psychosis including hallucinations or delusions. Review of R49's electronic medical record (EMR) revealed the following active physician orders: Oxycodone (opioid pain medication) 5 mg (milligram), two tablets by mouth every eight hours PRN. Start date: 4/23/2025. Tramadol (opioid pain medication) 50 mg, one tablet by mouth every six hours PRN. Start date: 4/8/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R49's care plan revealed no specific focus area, goals or non-pharmacological interventions listed related to R49's pain management. Further review revealed no focus areas, goals or interventions related to opioid use, including interventions for monitoring for adverse effects of the medications. On 6/5/2025 at 8:43 a.m., the Director of Nursing (DON) was asked regarding the administration of PRN medication. The DON reported the expectation was to attempt non-pharmacological interventions per each resident's care plan prior to administration of the medication. During an interview on 6/5/2025 at 8:54 a.m., Registered Nurse (RN) T reported she was responsible for the development of resident care plans. During a review of R49's care plan at the time of the interview, RN T confirmed R49's care plan did not include focus areas, goals or interventions for pain or opioid use. RN T reported she was aware R49 was admitted post-surgical intervention for a left ankle fracture, experienced acute pain and was often administered PRN opioid pain medication. RN T acknowledged the information should be included in R49's care plan to accurately reflect the R49's condition and to provide guidance to staff while providing care for R49. Review of the facility policy titled, Goals and Objectives, Care Plans, revised 4/2009, revealed the following: Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: are resident oriented; are behaviorally stated; are measurable; and contain timetable to meet the resident needs . Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI00153232 Based on interview and record review, the facility failed to ensure care plans were revised to address supervision behaviors and prevent further abuse regarding two Residents (#14 and #40) of 13 residents reviewed for revision of care plans. This deficient practice resulted in care plans which did not reflect resident needs and had the potential for continued behaviors, including resident to resident abuse. Findings include: Resident #14 (R14) Review of the Minimum Data Set (MDS) assessment, dated 5/15/25, revealed R14 was admitted to the facility on [DATE] with active diagnoses that included Alzheimer's Disease, anxiety, and depression. R14 scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. Resident #40 (R40) Review of the MDS assessment, dated 5/15/25, revealed R40 was admitted to the facility on [DATE]. R40 scored a 3 out of 15 on the BIMS assessment reflective of severe cognitive impairment. Further review of the Electronic Medical Record (EMR) revealed R40 had a diagnosis of dementia. Section E Behavioral Symptoms: revealed R40 experienced physical behavioral symptoms directed toward others, i.e. Hitting, kicking, pushing, scratching, grabbing, abusing others sexually every 4 to 6 days. Review of a facility five-day investigation summary, submitted to the State Agency (SA) on 5/23/25 at 8:54 a.m., revealed the following: On 5/19/25 R40 groped R14's breast at 8:58 the incident occurred. Staff witnessed R14 slapping her hand on R40's shoulder repeatedly. When asked why R14 was doing that and they were pulled apart, R14 stated he squished my breast. I just wanted him to stop so I was hitting him . Review of resident care plans on 6/5/25 at 10:27 a.m., revealed no interventions or revisions to care plans for R14 or R40 following the resident-to-resident incident. During an interview on 6/5/25 at 10:32 a.m., the Director of Nursing (DON) reported he would expect new interventions would be in place for R14 and R40's care plans to monitor for adverse reactions from the event and/or interventions in place to prevent the incident from recurring. The DON reviewed the EMR and acknowledged no interventions or revisions to the care plans had occurred.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #263 (R263) Review of an admission Record revealed R263 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Enterococcus bacteremia (blood stream infection). Review of a Minimum Data Set (MDS) assessment for R263 with a reference date of 5/9/25 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated R263 was cognitively intact. In an interview on 6/4/25 at 2:08 PM., R263 reported staffing is so short he has to wait for assistant for long periods of time. R263 reported there are just not enough of them to help out the way they should be. R263 reported his call light took over 45 minutes the other night. In an interview on 6/4/25 at 9:35 AM., Certified Nurse Aide (CNA) C reported (staffing could be better, we struggle making sure everyone gets their showers on time or on their scheduled days. CNA C reported resident showers do get missed because the shower aide gets pulled to work the floor because of staff calling in or not showing up. Resident #264 (R264) Review of an admission Record revealed R264 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: neuropathy Review of a Minimum Data Set (MDS) assessment for R264 with a reference date of 6/1/25 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated R264 was cognitively intact. In an interview on 6/4/25 at 9:44 AM., R264 reported he has not been able to brush his teeth yet today because he can't reach over to the nightstand where the toothbrush, paste and spit basin is. R264 asked this surveyor to grab his items for him, he mentioned he knows how to use the call light, but it takes over 30 minutes to get a staff member to help him. In an observation and interview on 6/4/25 at 2:49 PM., R264's Family Member (FM) U came out into the hallway from his room and asked this surveyor for a washcloth and towel. FM U said the call light has been on for about 10 minutes. FM U reported R264 has complained a lot about it taking a long time for staff to come and answer call lights or help when he needs it. In an observation/interview on 6/4/25 at 3:15 PM., FM U and this surveyor were talking outside of R264's room while his call light was on. It was noted that multiple staff, CNA's, nurse and a maintenance staff passed the room without answering the call light. The maintenance staff asked if there was something he could do for us. FM U spoke up and said R264 needs a washcloth and towel The maintenance staff responded to FM U by saying I'll let the CNA know and walked off. This surveyor observed the call light noted above R264's door was lit and on for over 30 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/5/25 at 3:05 PM., RN B residents are missing showers, because of low staffing for the census and acuity of the residents. RN B reported there are agency staff that work the facility as well. RN B reported both residents and family members complain a lot, and lately they have been complaining that residents have soiled hands and fingers, their teeth are not being brushed, as well as the smell of urine a times. RN B reported when she passes medications or does assessments, she can tell baths/showers and oral care are not being completed quite often. This citation pertains to intake MI00152335.MI00152919 Based on observation, interview and record review, the facility failed to ensure adequate staffing to promote the physical, mental and psychosocial well-being of 11 Residents (#35, #16, #263, #264 and seven Confidential Residents) of 11 residents reviewed for sufficient staffing. This deficient practice resulted in missed showers, extended wait times for assistance and reported and/or inferred feelings of frustration, helplessness and anger based on the reasonable person concept. Findings include: Resident #16 (R16) On 6/3/2025 at 6:22 p.m., R16 was observed lying in bed watching television. R16's hair was noted to be disheveled and had a greasy appearance. Further observation revealed the skin on R16's face to be dry and flaky and multiple scabbed lesions were noted on his cheeks and forehead. When asked about the skin condition, R16 stated, I scratch and that he applies beef tallow to the lesions on a daily basis. When asked how often a shower is offered, R16 reported receiving a shower once per month on average. When asked why he was only receiving a shower once per month, R16 appeared angry and reported he required the assistance of two staff persons for transfers and care but there was often not enough staff scheduled to assist. Review of the Minimum Data Set (MDS) assessment, dated 4/16/2025, revealed R16 was admitted to facility on 8/30/2017 and had diagnoses including traumatic brain injury (TBI), lichen simplex (thick skin caused by itching and excessive rubbing), and facial dermatitis. Further review of the MDS assessment revealed R16 had moderate cognitive impairment, was always incontinent of bowel and bladder and was dependent on staff for Activities of Daily Living (ADLs). Review of R16's electronic medical record (EMR) revealed no record of R16's shower or bathing provision apart from Bath/Shower Sheet(s), for care provided on 2/13/2025 and 1/21/2025. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 at 2:00 p.m., Certified Nursing Assistant (CNA) H reported being the Shower Assistant for the facility. CNA H was asked how the residents were offered showers/bathing. CNA H stated, I go down the census list and when all residents have had a shower, I start over at the top of the list. When asked to clarify if residents were only receiving one shower per week, CNA H stated, Some get two if I get down the list and start over. CNA H reported her schedule was Monday through Thursday, 7:00 a.m. to 5:00 p.m. When asked who provided showers on her off days, CNA H reported showers were not provided on Fridays, Saturdays or Sundays. When asked if her only duty was to provide showers, CNA H reported showers were her main responsibility, but she often was pulled to the floor, to cover when the facility was short due to call ins and residents did not receive showers on those days. When asked who covered for her if she took time off, CNA H reported she recently took time off in May 2025 and was unsure what the facility did to provide showers in her absence. CNA H was asked to provide all shower records for 3/1/2025 through 6/4/2025. This surveyor was then presented with shower records for 3/10/2025 through 6/4/2025. When asked where the previous records were housed, CNA H reported previous records were scanned into the electronic EMR. CNA H was queried as to the facility process if a resident refuses a shower to which she reported if a resident refused a shower, a bed bath would be offered and if that was refused, nursing would be notified to document in the resident record. Review of the shower records provided by CNA H, including therapy records for the allotted period, and revealed R16 was provided a shower on the following dates: 3/10/2025 4/02/2025 4/16/2025 4/23/2025 4/29/2025 5/28/2025 Further review of the shower records revealed no documented refusals or reasons why R16 was not provided a shower/bath between 3/10/2025 - 4/02/2025 or between 4/29/2025 - 5/28/2025. It was noted R16 went 23 days with no shower/bath between 3/10/2025 - 4/02/2025 and 29 days with no shower between 4/29/2025 -5/28/82025. Review of R16's EMR revealed no nursing documentation of shower/bath provision or documentation regarding refusal of showers/baths from 3/10/2025 through 4/02/2025 and 4/29/2025 through 5/28/2025. Resident # 35 (R35) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/3/2025 at 7:43 p.m., R35 was observed in his room self-propelling around the room in his wheelchair. R35 had an ace-type wrap around his right lower leg and foot. The wrap was loose with one end of the wrap unfastened and dragging under the R35's foot. The outer layer of the wrap was soiled with what appeared to be dirt from the floor picked up when R35 self-propelled in his wheelchair. During an interview at the time of the observation, R35 was asked why his wrap had not been replaced or refastened to which he stated, They don't have time for that. When asked if there were sufficient staff to meet his needs, R35 stated, The shower aide went on vacation a couple of weeks ago and we didn't get showers. When she is here, she gets pulled to work on the floor because other people, they don't show up, and no one gives showers. R35 reported feeling frustrated and angry for not receiving the care, stating, I pay for it. Review of the MDS assessment, dated 3/1/2025, revealed R35 was admitted to the facility on [DATE] and had diagnoses including diabetes, peripheral vascular disease and anxiety. Further review revealed R35 was cognitively intact and required partial/moderate assistance for showers and bathing. Review of the shower records provided by CNA H for 3/10/2025 through 6/4/2025 revealed R35 received showers on the following dates: 3/10/2025 4/17/2025 4/24/2025 5/20/2025 5/29/2025 Further review of the shower records, including therapy records for the allotted period, revealed no documented refusals or reasons why R35 was not provided a shower/bath between 3/10/2025 - 4/17/2025 or between 4/24/2025 - 5/20/2025. It was noted R16 went 38 days with no shower/bath between 3/10/2025 - 4/17/2025 and 26 days with no shower between 4/24/2025 -5/20/2025. Review of daily staffing assignment sheets for April 2025 through May 2025, provided by the Director of Nursing (DON), revealed the following: CNA H was assigned as shower assistant on 26 out of 61 days reviewed. No shower assistant was assigned on 32 of 61 days reviewed. CNA H was reassigned from shower assistant to floor assistant on three of 61 days reviewed. It was noted no one was added to the schedule to replace CNA H on the days she was reassigned. During an interview on 6/5/25 at 2:05 p.m., the DON reported he does reassign staff to cover call-ins if no unscheduled staff are available to work. The DON was asked if he schedules staff to provide showers in CNA H's absence to which he reported he does not schedule a replacement shower assistant when CNA H is not working or when she is pulled to the floor. The DON reported therapy staff assist with showers and bathing when available. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential group meeting on 6/4/25 at 8:40 a.m., seven Confidential Residents of 13 in attendance agreed they did not receive showers for two weeks in May of 2025. CR1 reported that it was not the shower aides fault, she was on vacation . it was disgusting not having a shower for two weeks. CR2 reported the home was supposed to have someone take her place and give us showers but that did not happen . the shower aide should be able to go on vacation. CR3 reported the nursing home did not take care of it and we didn't get showers . other staff were supposed to give us showers. During an interview on 6/4/25 at 1:59 p.m., CNA H reported that residents get a shower once a week . I don't know who does the showers when I am not here. I don't have a record of the residents who received showers the week of May 12th thru May 16th which is very upsetting to me . all I have is a record of May 6th thru May 10th. CNA H provided a copy of the list of the showers that were completed May 6th thru May 10th. Review of the facility document titled Showers dated May 6th thru May 10 revealed that 30 of 55 residents did not receive a shower. During an interview on 6/5/25 at 10:41 a.m., the DON reported there was no shower person for the two weeks that CNA H was on vacation, but therapy did help with showers. During an interview on 6/5/25 at 11:44 a.m., OT M reported that therapy will assist with showers for people that are working with the therapy department. OT/Rehab Director M reported that one resident was given a shower by therapy the week of May 6th thru May 10th and two residents were given a shower by therapy the week of May 12th thru May 16th.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide behavioral health care needs to maintain the highest practicable level of physical, mental, and psychosocial well-being, for one Resident (#40) of one resident reviewed for behavioral care. This deficient practice had the potential for worsening behaviors. Resident #40 (R40) Review of the Minimum Data Set (MDS) assessment, dated 5/15/25, revealed R40 was admitted to the facility on [DATE]. R40 scored a 3 of 15 on the BIMS assessment reflective of severe cognitive impairment. Further review of the Electronic Medical Record (EMR) revealed R40 had a diagnosis of dementia. Section E Behavioral Symptoms: revealed R40 experiences physical behavioral symptoms directed toward others i.e. Hitting, kicking, pushing, scratching, grabbing, abusing others sexually every 4 to 6 days. Review of Progress Notes for R40 revealed the following pertinent entries: 3/9/25 . Resident has been inappropriate both physically and verbally with staff, resident groped this writer's buttocks two times this shift and was not easily redirected . 4/17/25 Resident was sexually inappropriate with staff today grabbing the Certified Nurse's Aide (CNA) vagina and sticking his finger in her bottom .Resident was mean and verbally aggressive today yelling at both staff and residents . 4/18/25 .Resident was sexually inappropriate with staff today while helping to transfer from the living room chair to wheelchair. Resident asked this writer to touch his penis 4/20/25 Resident has been verbally and sexually inappropriate with staff. Resident was verbally aggressive with residents today . 4/22/25 . Reported CNA that resident grabbed at her crotch during transfer . [R40} wheeled himself up behind a CNA, he proceeded to take his finger and run it across the cheek of her buttocks . 5/7/25 . Per nurse aide, resident has been sexually inappropriate this shift toward aide. He stated during care, do you like what you see? And proceeded to try to grab nurse aide inappropriately . 5/10/25 . Resident was sexually inappropriate with staff during toileting time . 5/14/25 Resident was sexual with staff during toileting time. Grabbling at her vaginal area and saying you want this because you like it . 5/19/5 R40 made sexually inappropriate gestures and assaulted a person . During an interview on 6/4/25 at 12:51 p.m., Social Services Designee, Staff I reported there is no outside behavioral health services for R40. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/25 at 1:01 p.m., Nursing Home Administrator (NHA) reported R40 has had numerous sexual behaviors towards staff over the past couple of months. R40 has not been seen by anyone for behavioral health support. During an interview on 6/4/25 at 1:55 p.m., Staff I reported [Hospital name] takes care of our resident's behavioral health, but no one has seen R40 regarding his behaviors. During a phone interview on 6/5/25 at 9:42 a.m., Licensed Practical Nurse (LPN) K reported R40's behaviors became very sexual in April 2025. During an interview on 6/5/25 at 10:35 a.m., the Director of Nursing (DON) reported he is unaware if the facility can call or set up outside behavioral services for R40. During an interview on 6/5/25 at 12:00 p.m., the NHA reported the facility can call for behavioral support services but was unable to provide proof of any behavioral support services for R40. Review of facility policy titled Behavioral Assessment, Intervention, and Monitoring, last revised 3/19, read in part, .The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure consistent follow-up and documentation of monthly medication regimen reviews (MRRs) for two Residents (#16 and #36) of five resident reviewed for MRRs. Findings include: Resident #16 (R16) Review of R16's MRRs documented in the electronic medical record (EMR) for the period of 11/1/2024 through 6/1/2025 revealed the following: 3/8/2025, 3:22 p.m. See recommendation. 6/1/2025, 11:02 p.m. See recommendation. Further review of R16's EMR revealed no documentation or pharmacy report indicating what the pharmacy recommendations were for 3/8/2025 or 6/1/2025. Resident #36 (R36) Review of 36's MRRs documented in the EMR for the period of 11/1/2025 through 6/1/2025 revealed the following: 1/19/2025, 5:07 p.m. See recommendation. 5/20/2025, 11:23 p.m. See recommendation. Further review of R36's EMR revealed no documentation or pharmacy report indicating what the pharmacy recommendations were for 1/19/2025 and 5/20/2025. On 6/5/25 at 8:43 a.m., the Director of Nursing (DON) was asked what the facility process was to ensure MRRs were completed in a timely manner. The DON reported he received recommendations from the pharmacy via email and followed up with the providers accordingly based on the recommendations. When asked how he ensures no recommendations were missed, the DON reported nursing staff audit the charts to ensure follow up on any recommendations corresponding with the monthly pharmacy reviews. The DON was asked to provide the missing pharmacy recommendations for R16 and R36. On 6/5/2025 at 2:05 p.m., the DON reported he was unable to locate or provide the requested pharmacy recommendations for R16 and R36. Review of the facility policy titled, Medication Regimen Review (MRR) and Reporting, last reviewed 9/9/2022, revealed the following: (continued on next page)

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	235526	A. Building B. Wing	06/05/2025

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

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In accordance with state regulations, the consultant pharmacist or clinical pharmacist at the provider pharmacy works with the nursing care center nursing staff to gather pertinent information related to the resident's status . The findings are communicated to the director of nursing or designee. These findings are documented and filed with other consultant pharmacist recommendations in the resident's chart . A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to director of nursing, and medical director and the care planning team . The consultant pharmacist and the nursing center follows up on the recommendations to verify that appropriate action has been taken.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consistently document pain assessments and document/utilize non-pharmacological interventions prior to the administration of PRN (as needed) opioid pain medication for one Resident (#49) of five residents reviewed for unnecessary medications, resulting in the potential for adverse medication effects and/or physical dependence on controlled medications. Findings include: Resident #49 (R49) Review of the Minimum Data Set (MDS) assessment, dated 4/15/2025, revealed R49 was admitted to the facility on [DATE] and had diagnoses including left ankle fracture, anxiety and schizophrenia. Review of the MDS Section J - Health Conditions, revealed R49 almost constantly experienced pain was receiving scheduled and PRN (as needed) pain medication. Further review of the MDS assessment revealed R49 was cognitively intact and had no behaviors of psychosis including hallucinations or delusions. Review of R49's electronic medical record (EMR) revealed the following active physician orders: Oxycodone (opioid pain medication) 5 mg (milligram), two tablets (10 mg) by mouth every eight hours PRN. Start date: 4/23/2025. Tramadol (opioid pain medication) 50 mg, one tablet by mouth every six hours PRN. Start date: 4/08/2025. Review of R49's medication administration records (MAR's) for May and June 2025 revealed the following: Oxycodone 10 mg was administered to R49 on 69 occasions. Tramadol 50 mg was administered to R49 on 35 occasions. Further review of the MAR's and EMR revealed only four pain assessments to correspond with the administration of the oxycodone 10 mg and four pain assessment to correspond to the administration of the tramadol 50 mg were documented. There was no documentation of the use of non-pharmacological interventions aimed at relieving R49's pain prior to the administration of any of the doses of PRN opioid pain medications. On 6/5/25 8:43 a.m. the Director of Nursing (DON) was queried as to what procedure was for determining the need for PRN pain medication. The DON reported nursing was expected to attempt the use of non-pharmacological interventions per the resident's care plan prior to administering the PRN medication and document the intervention and the result in the EMR. When asked if pain assessments should be completed to correspond with each administration of the PRN pain medication, the DON confirmed it was a standard of practice to assess pain level prior to opioid administration. Review of the facility policy titled, Medication Management, provided by the DON and last reviewed 9/09/2022, revealed no process or information related to the administration of opioid medications.

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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. Based on observation, interview, and record review, the facility failed to facility failed to ensure drugs and biological's were stored and discarded according to professional standards and ensure a locked medication room had a functional door handle/lock for 1 of 2 medication storage rooms, and 1 of 3 medication carts reviewed for storage of medications resulting in the potential for negative side effects from outdated or ineffective drug therapy and accidental wrong medication ingestion and drug diversion. Findings include: In an interview/observation on 6/4/25 at 2:07 PM., Registered Nurse (RN) A reported the main medication room near the front door and administration offices had an issue for a while where it would slam shut very hard when leaving the room. RN A reported she thought maintenance fixed it, but clearly it is not fixed. RN A reported it would close so hard it would scare people. RN A stated they thought maintenance might have adjusted it. The medication room door did not appear to be shutting and securely closing while observing medication administration. (While observing medication administration pass, another surveyor near the main medication room in view was able to push open the door which was not latched and secured). During an inspection of a medication cart on 6/5/25 at 8:59 AM., Licensed Practical Nurse (LPN) E accompanied this surveyor with the inspection of Medication Cart-B It was noted 2 loose pills located in the 2nd drawer down which were unidentified. 1 unidentified pill was found on the bottom of the 3rd drawer underneath medication packages. Observed behind the left hand drawers on the bottom of the inside medication cart a plastic bag with a tube of prescription medication diclofen 1 % gel dated 4/02/2023 . LPN E reported each nurse is responsible to clean the medication carts after their shifts, and ensure medications are not dropped in the drawers, nothing is spilled, and the controlled medications are accounted for. LPN E reported there should not be loose medications underneath the medication packages. During an inspection of the LTC-Main Medication Room on 6/5/25 at 9:33 AM., (which throughout the survey was noted to be unlocked) it was discovered multiple over the counter medications were in unlocked cabinets. On the floor to the right side of the medication room there were 3 large pharmacy totes with multiple resident medications packages (which held hundreds of medications). LPN E reported these medications were from discharged residents, residents who had passed away, and some were discontinued prescription medications. LPN E reported she was unsure why there were so many medications in the medication room, and normally pharmacy picks the medication totes up nightly. Some of the medications that this surveyor observed and inspected included but were not limited to, bags of vancomycin IV (intravenous-antibiotic solution bags), vials of immunizations, multiple antidepressant medications, single use vial injectable's of Lovonox (blood thinner with a high alert red), individual insulin pens, and lidocaine patches. LPN E reported the totes were there at least a few days but again, reported she was unsure why. LPN E reported the medication door latch was having some issues a week or so ago, and was not closing and latching, but she thought maintenance fixed it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility Policy with a revision date of 4/2007 revealed: Storage of Medications Policy Statement The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 5. Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications. 6. Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use, and shall be stored separately from regular medications. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly. 10. Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys On 6/4/25 at 11:18 AM, the medication storage room near the facility main entrance lobby area was discovered to be unlocked and unsecured. There were no staff members in the lobby area which the medication room door opens into. There were no staff in the medication room. The medication storage room was accessible to non-authorized personnel. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 at 3:36 PM, the same main medication room was discovered to be unlocked and unsecured. The door was able to be pushed open and had not latched. When the door was allowed to swing freely closed it still did not latch or lock. RN J was nearby and was alerted to the unlocked, unsecured medication room. RN J observed this door was not locked and was easily pushed open. RN J said, I will tell maintenance. It should be locked. On 6/5/25 at 7:30 AM, the same main medication room was discovered to be unlocked and unsecured. The Director of Nursing (DON) was standing at the medication cart approximately 15 feet away and able to observe the medication storage room door was unlocked and accessible to non-authorized personnel. The DON said, Oh I will call maintenance. The DON then continued working at his medication cart. .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to identify areas of improvement through its Quality Assurance and Performance Improvement (QAPI) program of five concerns, Advanced Beneficiary Notification (ABN), care plan updates, medication consents, proper reporting of abuse, and Preadmission Screening and Annual Resident Review (PASARR) identified by the survey team. The deficient practice has the potential for negative resident outcomes, and placed residents at risk for harm due to lack or proactive system-level interventions. Findings include: On 6/5/25 at 1:20 PM, an interview was conducted with the Nursing Home Administrator (NHA) regarding the facility's current QAPI process and Performance Improvement Plans (PIP) currently being conducted by the facility. The NHA stated the facility had a PIP in progress related to wound care, and another PIP related to weight measurement. The NHA stated that the facility had started PIPs for ABN, and medication consents based on the identified concerns brought up by the survey team during the recertification process. The NHA stated the Interdisciplinary team (IDT) met every morning and rounded the facility, to identify areas of concern. The NHA indicated the facility had multiple issues within the MDS department. The NHA stated this affected timely issuance of ABN's, effective care planning, coordination of PASARR with the OBRA (Omnibus Reconciliation Act) office, and completion of medication consents. All of which were part of the MDS department duties. The NHA indicated the facility was researching the possibility of utilizing outside resources for MDS functions. The NHA stated facility staff could take issues to their unit managers, the members of the IDT, or email the compliance officer. The NHA stated the facility did not have any other ways in which to bring for concerns forth anonymously. The NHA was unable to identify why the QAPI program had not identified the concerns brought forth during the recertification survey process.