STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235529	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Novi	24500 Meadowbrook Rd Novi, MI 48375

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2588311.Based on observation, interview and record review, the facility failed to identify upon admission and provide treatment and services for a Stage Three pressure ulcer (having full-thickness skin loss, not involving underlying fibrous tissue) for one resident (R4) of four residents reviewed for pressure wounds resulting in a delay of treatment, pain and worsening of a sacral pressure wound. Findings include: Clinical record review revealed R4 was admitted to the facility on [DATE] for osteomyelitis (infection in the bone) of the left foot requiring amputation of the toes and required administration of intravenous (IV) antibiotics via PICC (Peripheral Inserted Central Catheter) line, had Acute Kidney Injury (AKI) due to kidney failure and required hemodialysis. R4 was alert, orientated, and capable of making their needs known.On 4/6/26 around 10:30 AM, during initial introductions, R4 voiced a concern that their dressing on their bottom was missed being changed over the weekend. R4 said the open wound on their backside was present before they were admitted to the facility and the other hospital they were transferred from were putting ointment on it. When asked if they have pain in the sacral area, R4 replied they can feel pain around the opening of the wound, and it becomes more intense when they are in a sitting position. The dressing helps cushion the area, but they still need to get it healed up.Record Review of facility documentation identified R4 had a Facility Acquired Unstageable Pressure Ulcer.Record review of the hospital discharge paperwork documented on 3/9/26 at 2:53 PM wound/ulcer assessment midline center sacral injury Stage Three Pressure Ulcer, with wound management to include cleanse, apply enzymatic debriding agent, gauze, and a silicone dressing.On 4/7/26 at 10:58 AM, the Director of Nursing (DON) was interviewed and questioned about the Nursing Progress Note they authored on 3/17/26 at 2:09 PM .New skin Issue. Location: Coccyx.New: new wound. Pressure ulcer staging: Unstageable pressure .It is unknown how long the wound has been present .The DON was questioned how this concern came to their attention as documented on 3/17/26, five days after admission, (3/12/26) the DON responded they received a referral from a centralized admission coordinator and communicated the sacral wound was present prior to their admission to the facility.A record review was conducted with the DON (of the hospital discharge paperwork) which documented on 3/9/26 at 2:53 PM wound/ulcer assessment midline center sacral injury Stage Three with wound management dressing changes to be cleansed, apply enzymatic debriding agent, gauze, and silicone dressing.The DON confirmed Nursing responsibilities regarding new resident skin assessments said they must look at every inch of their skin, place a wound consult, and implement a treatment plan until the wound consultation is completed. The DON recognized the admission Licensed Practical Nurse (LPN) X did not do a thorough skin assessment upon admission and missed the sacral wound.Clinical record review of the Nursing Comprehensive Evaluation dated 3/13/26 at 1:10 AM performed by Licensed Practical Nurse (LPN) X documented R4's skin having right toe amputated, left toe amputated, and a chest wall dialysis port.On 4/7/26 at 1:04 PM, a telephone interview was conducted with LPN X and when asked if they recalled performing the skin assessment for R4, they recalled the toes were amputated, had a port for dialysis and a small area on their coccyx. When asked why the coccyx was not documented on the skin assessment, they sounded surprised that it was not documented and then replied that I must have forgot to document it. (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review revealed LPN X placed a wound consult order and responded that all new admits get wound consults, they automatically trigger under the admission nurse, but only residents that have a paper placed in the wound binder are seen. There is no electronic notification to Providers.On 4/7/26 at 1:45 PM, a telephone interview with Wound Care Specialist JJ confirmed they are notified of wound consults when they come on site by LPN M and they inform them who to see. When questioned when they were notified that R4 needed to be seen, Wound Care JJ replied they were not formally consulted. R4 overheard them tending to the roommate and said they had an open wound on their backside and amputated toes. JJ stated. [R4] overheard I was with wound care and asked if I could take a look (at their wounds). It was at that time we observed [R4] had an unstageable pressure ulcer, and I then initiated a treatment plan. If it wasn't for [R4] self-reporting, I would have never assessed them.Treatment Order was initiated on 3/17/26 to cleanse coccyx topically every day shift, pat dry, apply moist Dakins (antiseptic) gauze with Santyl (medication removes dead skin tissue, promotes wound healing) and cover with Allevyn (foam) dressing every day shift and as needed.On 4/8/26 11:30 AM, a pressure ulcer dressing observation with LPN Q was conducted. R4 was observed lying in bed alert and orientated. An incontinent brief was removed, and R4's coccyx area was observed with no dressing exposing an unstageable coccyx pressure ulcer open split horizontal wound with yellow colored slough. When inquired why there was no dressing, R4 stated they had a made a mess around three/four this morning and no one ever put a dressing back on.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent avoidable falls for three residents (R#'s 5, 60, and 50) of five residents reviewed for falls resulting in R5 sustaining a fracture to their left shoulder causing pain and hospital care, and provide supervision for wandering residents for two residents (R#'s 18 and 81) of two residents reviewed for supervision. Findings include: On 4/6/26 at approximately 12:19 PM, R5 was observed lying in bed. Their left arm was in a sling and assist bars were observed on both sides of the bed. R5 was alert and able to answer all questions asked. R5 reported that they were admitted to the facility on [DATE], primarily to receive in-house Dialysis care. They noted that on day two of their stay, they needed to take a bowel movement and needed assistance as they are immobile. At that time, they did not have assist bar(s) in place and further their needed their mattress changed. They noted that the needed mattress was in the room but had not yet been placed on their bed. R5 further explained that in the evening of 3/4/26 the CNA turned them on their side and placed a bedpan on the bed. The CNA left the room and when they were done, they pushed their call light on and continued to remain on their left side. As they were waiting for assistance, R5 started to slip, could not hold on to anything and rolled off the bed and landed on the floor. R5 further stated that as they rolled their call light got tangled underneath them. They noted while lying on the floor they started to yell for help and finally a nurse came to their room. After the fall they had significant pain in their left shoulder and arm. Following the fall R5 noted they were transferred to the hospital and told they had a fractured shoulder. A review of R5's hospital records revealed, in part: .3/4/26.(R5) lives at (facility) brought in to the emergency department via EMS (emergency medical services) with a chief complaint of left arm pain.Patient states that she is bed ridden.earlier today she rolled over to use the commode, however fell.notes she is non-ambulatory.Radiology Impressions: XR (x-ray)Shoulder – comminuted minimally displaced humeral head fracture (top of arm). A review of R5's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: acute kidney failure, morbid obesity, and dependence on dialysis. A review of R5's Minimum Data Set (MDS) noted the resident was cognitively intact. R5's initial comprehensive evaluation (dated 3/3/260 noted the following: .new admission.recent weight: 432.7 lbs.obtained mechanical lift.bowel.continent.Adl (activities of daily living).Transfers: Total assist.Bed Mobility: [NAME] assist.Ambulation: bedrest.non-ambulatory .Functional Ability Deficit Care Plan.Focus: has a functional ability deficit and requires assistance with self-care/mobility.positioning bars: No.History of falls: Yes.Does the resident take medications that may increase falls.Yes.Focus: is at risk for fall related injury. A review of the facility Incident/Accident (IA) Report revealed the following: .Alleged Incident.Date: 3/4/26.Resident (R5).Brief Description: Nurse was alerted to resident's room. (R5) was observed lying on the floor. She complained of left shoulder pain. Was transported to the hospital for evaluation. Upon return facility was notified of a left shoulder fracture.Summary of Resident Interview.Guest (R5).Said that she needed to have a bowel movement. CNA came to the room, rolled her on her side.left out of the room. She felt a lump in the mattress.could not move her leg and she fell out of bed.Staff Member Interview (RN MM).heard yelling. Went to (R5's) room and observed her lying on the floor. Called for assistance and 911.Staff Member Interview (CNA NN).resident's call light was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	on.resident said she needed to have a bowel movement.the resident asked her to roll her on her side.left out of the room to give privacy.was out of the room for about 15 minutes when heard a page for assistance. On 4/7/26 at approximately 1:13 PM, an attempt to interview CNA NN via phone was made. A voice mail could not be left. The facility was asked to have CNA NN contact the Surveyor. No contact was received by the end of the survey. On 4/8/26 at approximately 8:29 AM, a phone interview was conducted with RN MM. RN MM reported they had been employed by the facility for a little over a year and generally worked the 7 PM to 7 AM shift. RN MM was asked about the incident involving R5 on 3/4/26. RN MM reported that they were working that evening and while in the hall they could hear someone yelling loudly. RN MM noted that it took a bit of time, but they were able to figure out that the screaming was coming from R5's room. They entered the room and could initially hear the resident but could not see them. They were able to locate them on the floor closest to the wall near the window. They immediately assessed the resident, determined that they were in significant pain and called 911 and EMS (Emergency Medical Services) to have the resident transferred to the hospital. RN MM was asked if they were aware of how R5 fell. They reported that CNA NN turned R5 on their side and placed a bedpan/commode on the bed, they then left the room. RN MM noted that CNA NN should never have left the resident alone as they were bedbound, obese and had nothing to hold on to while on their side. RN MM reported that following in the incident they provided 1:1 training with CNA NN. The Administrator was asked to provide CNA NNs personnel file. The file indicated the resident was hired as a CNA on or about 1/20/26. There were no documents in the file that indicated CNA NN had received either initial training upon hire or 1:1 training regarding R5's fall. On 4/8/26 at approximately 11:58 AM, an interview with the DON (Director of Nursing) was conducted. The DON was asked about the education provided to CNA NN. The DON noted that they believed they were educated not to leave the resident alone on their side based on their mobility status. The DON noted that they did not have a copy of the CNA's training. The Administrator was interviewed on 4/8/26 at approximately 4;45 PM and reported that they could not locate any documents related CNA MM education training. The Administrator was also asked about the incident involving R5 and noted that they were aware that CNA NN should not have left R5 on their side. R60 On 4/6/26 at 2:05 PM, a review of a progress note entered into the record on 3/30/26 at 8:06 PM by the DON was reviewed and read, .IDT (interdisciplinary team) met to discuss the fall (on 3/25/26) The resident was in the room for 6minutes [sic] when the nurse walked pass [sic] and saw her sliding from the wheelchair. She didn't make it to the floor on her own, the nurse guided her down to the when [sic] she couldn't get her back up into the wheelchair . It was observed that her seatbelt wasn't fastened. Intervention Education provided to the cna [sic]. On 4/7/26 at 11:57 AM, an interview was conducted with the facility's DON regarding R60's fall. At that time, the DON confirmed R60 was supposed to have their seatbelt buckled and the CNA did not ensure it was secured. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R50 On 4/7/26 at 10:58 AM, a review of R50's progress notes was conducted and revealed a note dated 1/13/26 at 10:11 PM entered into the record by the facility's DON that read, IDT (interdisciplinary team) met to discuss the fall. The resident was observed on the floor in her room bedside her bed. It was noted that the HOB (head of bed) was elevated too [sic] r/t (related to) the resident having seizures and a jerking motion that she sometimes does while in bed. The resident did have anewer [sic] cna [sic] that was taking care of her .Intervention CNA educated on ensuring residents bed is in proper position. On 4/7/26 at 11:59 AM, an interview was conducted with the facility's DON regarding R50's fall. They explained the fall occurred at night and while the bed was in the lowest position, the head of the bed should have been flat, not elevated in order for R50 to sleep. They further explained that due to the elevated head of the bed and R50's positioning it caused them to fall out of the bed. R18 and R81 On 4/6/26 at 1:16 PM, R18 was observed in their Merry [NAME] (a specialized framed four-wheeled walking aid designed to surround a user. It acts as a combination walker and seat, featuring a built-in rear seat for resting, a bar across the front, and a safety belt that is fastened in between the legs) on the B-unit. R18 was observed to enter R81's room at the end of the hall. CNA (Certified Nurse Aide) 'F' was overheard to call up the hall to R18 in an attempt to redirect them from entering R81's room, however; R18 proceeded to enter R81's room. CNA 'F' did not proceed to R81's room to re-direct R18, rather they entered another room further down the hall. After R18 entered R81's room, R81 was overheard to call out, Help me, I have an unwanted person in here. Staff did not respond to R81's calls for help and R18 exited R81's room on their own without staff re-direction. On 4/7/26 at 12:02 PM, the Director of Nursing (DON) was made aware of the observation of CNA 'F' not going and re-directing R18 and said they should have went to her and redirected her away from R81's room.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review the facility failed to ensure sufficient nurse staffing to meet the needs of multiple residents, including, but not limited to (R101, 55, 79, 44, 58, 17) and 11 anonymous residents that participated in the resident council meeting, resulting in the potential for delayed care for activities of daily living, medication administration and treatments to all residents residing in the facility. Findings include: On 4/6/26 at 9:28 AM, R58 was observed lying in bed. R58 was asked about care in the facility. R58 explained frequently it took staff approximately one hour to answer the call light. R58 was asked what time of day was usually the longer wait. R58 explained at night and on the weekends were the longest waiting time. On 4/6/26 at 9:30 AM, R101 was heard crying from the hallway. At that time, R101 was interviewed about the care in the facility. R101 stated, I just want to go home and explained the last time their incontinence brief was changed was around 11:00 PM the previous night (4/5/26). R101 reported when she was sleeping, she did not like to be woken up but typically woke up early enough to be changed at the end of the midnight shift. R101 reported at that time she had not been changed. R101 was tearful during the interview and reported the facility did not have enough staff to care for the residents. R101 reported they were supposed to take her to the toilet to use the bathroom, but at times there were not enough staff to assist, and she had to wet my pants. At that time, R101's roommate nodded her head to indicate nobody had been in to change R101 since the previous night. R101 and the roommate were observed with Styrofoam cups dated 4/5/26 7:00 AM to 7:00 PM. Both residents indicated water was passed on the morning of 4/5/26 and not passed since. On 4/6/26 at approximately 9:41 AM, R55 was observed lying in bed. The resident reported that they are often left wet in bed and on the previous evening (4/5/26) there was only one person working on their hall. On 4/6/26 at 10:04 AM, R79 was observed with a Styrofoam water cup dated 4/5/26 7:00 AM to 7:00 PM. When queried about whether she had fresh water, R79 shook the cup which was empty and said nobody passed fresh water since Sunday morning (4/5/26). On 4/6/26 at 12:01 PM, R17 was observed sitting in a wheelchair in their room. R17 was asked about care at the facility. R17 explained only the CNAs would ever change him or get water, the nurses would not help, they were too busy. R17 was asked about the food at the facility. R17 explained he needed assistance to eat, and by the time someone got around to assist him, the food was cold and he did not want to eat it. On 4/6/26 at 12:20 PM, R101 reported she had not yet been changed and said they would do it when she received a shower after lunch. On 4/7/26 at 10:00 AM, an interview was conducted with 11 residents who wished to remain anonymous. Four of 11 residents reported they felt there was not enough staff to care for the residents. One resident said they changed CNAs to work 12-hour shifts instead of eight hours, but they got burned out and then they quit, which leaves the facility short staffed. The same resident reported on the evening of Easter Sunday that a nurse did not come in, and another nurse had to cover the whole C (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	unit. Another resident said nurses often have to cover multiple units. Three residents reported issues with other residents wandering into their rooms and said there were not enough staff to supervise them. One resident said the wandering resident sometimes take their belongings. When it was short staffed, the residents reported the CNAs would tell them they have to do other things before they can assist them and often times, they do not come back. One resident reported they were not provided incontinence care in a timely manner, most recently on Easter Sunday. They reported their brief was changed at 11:30 PM on 4/5/26, but not again until 4/6/26 at 3:00 PM when they were given a shower. Another resident said the staff do not return after answering the call light. Nine of 11 residents reported they did not receive fresh water every day. One resident said it was a chronic problem. Another resident said they went a whole day without water. Multiple residents said they ask a CNA for water and because they split the room with another CNA (one CNA is assigned to a resident in the room and another CNA is assigned to their roommate), if they asked for water, the roommate's CNA said they were not their CNA and did not get them water. One resident said they are not given fresh water at night and if they ask the CNA, they said they would bring it but never came back. The resident reported that it happens often, but most recently on Easter Sunday (4/5/26). The residents reported they thought this was due to the facility being short staffed. The facility was asked to provide their weekend staffing schedule for 4/5/26. A review of the schedule indicated several WNBI (will not be in) nursing staff. Punch cards were reviewed and it was determined that on the 7 PM to 7 AM shift (4/5/26) there were two CNAs (herein after CNA OO and CNA PP) working the C and D hall and no nurse was assigned to the D hall and further no nurse started working the C hall until approximately 8:15 PM when Nurse MM punched in. On 4/7/26 at 2:01 PM, CNA 'EE' was interviewed by phone and asked about staffing at the facility. CNA 'EE' explained there was usually not enough staff, she would have 16 or 17 residents. there were a lot of residents that required mechanical lifts, or feeding assistance and several that needed to be supervised due to wandering. CNA 'EE' was asked if the nurses would help the CNAs. CNA 'EE' explained some of the nurses would help pass meal trays if they felt like it, but do not do anything else, they would leave the call light on and tell the CNA that the resident wanted water. CNA 'EE' was asked if the dining room was open on weekends. CNA 'EE' explained it was sometimes open and sometimes not due to staffing, either no nurse or not enough kitchen staff. On 4/7/26 at approximately 2:27 PM, a phone interview was conducted with CNA PP. They reported working for the facility for over 35 years and generally works the evening shift. When asked about staffing on 4/5/26 they reported that there were so many call ins that day and they had to work both the C and D halls with CNA OO. They further noted that it was hard to get all their work completed but tried to ensure care the best they could. On 4/7/26 at approximately 2:31 PM, a phone interview was conducted with CNA OO. CNA OO reported they have worked at the facility for approximately 25 years. When asked about staffing, specifically on 4/5/26, they reported that there were several call-ins and they were assigned to care for staff in both the C and D hall with one other CNA. They noted that there was not a specific nurse assigned at the start of the shift. On 4/7/26 at 3:30 PM, an interview was conducted with CNA 'W' via the telephone. CNA 'W' confirmed they worked second shift (7:00 PM to 7:00 AM) on 4/5/26. CNA 'W' reported it was short staffed on the A Hall that night. CNA 'W' reported the staff work together the best they can when it's short, but it was often short. CNA 'W' reported they were assigned to approximately 17 residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/7/26 at approximately 4:09 PM, a phone interview was conducted with Nurse QQ. Nurse QQ was asked about staffing on 4/5/26. They reported they started working at the facility about 3 weeks ago and noted that on 4/5/26 they worked the 7AM to 7 PM shift on the D hall. They indicated that at the end of the shift, there was not a nurse in the building to replace them. They noted that they contacted the Director of Nursing (DON) who instructed them to sign off with another day nurse (Nurse CC) and leave the keys to the cart in the DON's office. Nurse QQ further reported that staffing has been very low since they started at the facility, and many times have asked them to cover two halls at a time. They noted at times it is hard to cover all the needs of the residents. On 4/8/26 at approximately 8:49 AM, a phone interview was conducted with Nurse MM. Nurse MM reported that they have been employed by the facility for over a year and generally work the 7 PM to 7 AM shift. When asked about scheduling on 4/5/26 Nurse MM reported that they were not scheduled to work on that day and received a call from the DON. The DON asked them to cover the 7PM shift to 7 AM shift and agreed to work that evening however, they told the DON they could not start at 7 PM. The DON noted that the keys to the medication cart on the D hall would be found in their office. Nurse MM reported they started on the floor with the residents at about 9:30 PM. On 4/8/26 at approximately 1:43 PM, the Administrator was interviewed about staffing in general and the schedule for 4/5/26. The Administrator reported that they changed the scheduling for both CNAs and Nurses to 12-hour shifts and have noticed many call-ins. With respect to 4/5/26, the Administrator confirmed that there were several call-ins and no nurse showed up for the evening shift. On 4/8/26 at approximately 2:33 PM, a visitor to the facility (herein after visitor RR) reported that the facility was always short staffed and was told by the DON not to report concerns to the Administrator regarding staffing. Visitor RR further noted that the resident they were visiting did not get up and out of bed until 11:30 AM on 4/5/26 and generally likes to get up at 9 AM. On 4/8/26 at approximately 3:44 PM, an interview was conducted with the DON. The DON was asked about staffing concerns generally and what occurred on 4/5/26. The DON confirmed that there were several call-ins and on the 7 PM to 7 AM shift on 4/5/26 a nurse called in sick and another did not show up. They stated that they did not work that day but contacted Nurse MM who was not scheduled to work but did show up later that evening. The facility policy titled, Nursing Staffing (revised 9/14/23) was reviewed and documented in part: .Policy: The nursing service department provides 24 hours nursing services.The facility ensure sufficient nursing staff with the appropriate competencies and skills set to provide nursing services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident evaluations and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population. On 4/6/26 at 9:28 AM, R58 was observed lying in bed. R58 was asked about care in the facility. R58 explained frequently it took staff approximately one hour to answer the call light. R58 was asked what time of day was usually the longer wait. R58 explained at night and on the weekends were the longest waiting time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/6/26 at 10:03 AM, R44 was observed lying in bed. R44 was asked about call light response times. R44 explained at night and on the weekend the wait was an hour or longer. R44 was asked if he thought the long wait time was due to staffing levels. R44 explained sometimes it was because there was not enough staff and sometimes it was because the staff on midnights were sleeping. On 4/6/26 at 12:01 PM, R17 was observed sitting in a wheelchair in their room. R17 was asked about care at the facility. R17 explained only the CNA's would ever change him or get water, the nurses would not help, they were too busy. R17 was asked about the food at the facility. R17 explained he needed assistance to eat, and by the time someone got around to assist him, the food was cold and he did not want to eat it. On 4/7/26 at 2:01 PM, CNA 'EE' was interviewed by phone and asked about staffing at the facility. CNA 'EE' explained there was usually not enough staff, she would have 16 or 17 residents. there were a lot of residents that required mechanical lifts, or feeding assistance and several that needed to be supervised due to wandering. CNA 'EE' was asked if the nurses would help the CNA's. CNA 'EE' explained some of the nurses would help pass meal trays if they felt like it, but do not do anything else, they would leave the call light on and tell the CNA that the resident wanted water. CNA 'EE' was asked if the dining room was open on weekends. CNA 'EE' explained it was sometimes open and sometimes not due to staffing, either no nurse or not enough kitchen staff. On 4/6/26 at 9:30 AM, R101 was heard crying from the hallway. At that time, R101 was interviewed about the care in the facility. R101 stated, I just want to go home and explained the last time their incontinence brief was changed was around 11:00 PM the previous night (4/5/26). R101 reported when she was sleeping, she did not like to be woken up but typically woke up early enough to be changed at the end of the midnight shift. R101 reported at that time she had not been changed. R101 was tearful during the interview and reported the facility did not have enough staff to care for the residents. R101 reported they were supposed to take her to the toilet to use the bathroom, but at times there was not enough staff to assist, and she had to wet my pants. At that time, R101's roommate, R22 nodded her head to indicate nobody had been in to change R101 since the previous night. R101 and R22 were observed with Styrofoam cups dated 4/5/26 7:00 AM to 7:00 PM. Both residents indicated water was passed on the morning of 4/5/26 and not passed since. On 4/6/26 at 10:04 AM, R79 was observed with a Styrofoam water cup dated 4/5/26 7:00 AM to 7:00 PM. When queried about whether she had fresh water, R79 shook the cup which was empty and said nobody passed fresh water since Sunday morning (4/5/26). On 4/6/26 at 12:20 PM, R101 reported she had not yet been changed and said they would do it when she received a shower after lunch. On 4/7/26 at 10:00 AM, an interview was conducted with 11 residents who wished to remain anonymous. Four of 11 residents reported they felt there was not enough staff to care for the residents. One resident said they changed CNAs to work 12-hour shifts instead of eight hours, but they got burned out and then they quit which leaves the facility short staffed. The same resident reported on the evening of Easter Sunday a nurse did not come in and another nurse had to cover the whole C unit. Another resident said nurses often have to cover multiple units. Three residents reported issues with other residents wandering into their rooms and said there was not enough staff to supervise them. One resident said the wandering resident sometimes take their belongings. When it was short staffed, the residents reported the CNAs will tell them they have to do other things before they can assist them and often times, they do not come back. One resident reported they were not (continued on next page)

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	235529	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	provided incontinence care in a timely manner, most recently on Easter Sunday. They reported their brief was changed at 11:30 PM on 4/5/26, but not again until 4/6/26 at 3:00 PM when they were given a shower. Another resident said the staff do not return after answering the call light. Nine of 11 residents reported they did not receive fresh water every day. One resident said it was a chronic problem. Another resident said they went a whole day without water. Multiple residents said they ask a CNA for water and because they split the room with another CNA (one CNA is assigned to a resident in the room and another CNA is assigned to their roommate), if they asked for water, the roommate's CNA said they were not their CNA and did not get them water. One resident said they are not given fresh water at night and if they ask the CNA, they said they would bring it but never came back. The resident reported that happened often, but most recently on Easter Sunday (4/5/26). The residents reported they thought this was due to the facility being short staffed. On 4/7/26 at 3:30 PM, an interview was conducted with CNA 'W' via the telephone. CNA 'W' confirmed they worked second shift (7:00 PM to 7:00 AM) on 4/5/26. CNA 'W' reported it was short staffed on the A Hall that night. CNA 'W' reported the staff work together the best they can when it's short, but it was often short. CNA 'W' reported they were assigned to approximately 17 residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service and hydration areas resulting in the potential to spread foodborne illness to all residents. Findings Include:On 04/06/2026 at 8:55 AM during an initial kitchen tour observed in the upright cooler: opened container of hummus with facility marked use by dates of 3/27-4/4 and an opened package of sliced cooked turkey breast with facility marked use dates of 3/31-4/5. Dietary staff member 'LL' discarded upon observation. According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A) .On 04/06/2026 at 9:32 AM observed (2) of the nursing hydration carts getting prepared for use on the units. Each cart had an attached mesh bag for storage of the ice scoop. On both carts the storage bags were soiled/discolored on the bottom interior and not removable for routine cleaning. The mesh bags were also observed not covered, with the stored ice scoop exposed to potential contamination when in the unit hallways. One of the storage bags was observed frayed and torn. During this observation, dietary staff member 'LL' confirmed seeing the soiled/discoloration on the storage bags and indicated that dietary staff does clean and sanitize the food contact equipment (coolers and ice scoops), but the hydration cart unit and ice scoop storage would be a nursing staff responsibility. According to the 2022 FDA Food Code section 4-202.16 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance.According to the 2022 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLEUSE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination On 04/06/2026 at 9:47 AM in the dining room, observed the ice machine bin drain line soiled with a black substance. At the time of observation, Dietary Manager (DM) 'KK' cleaned the exterior surface, but the interior was unable to be cleaned. DM 'KK' indicated they would follow up with maintenance. According to the 2022 FDA Food Code section 6-501.18 Cleaning of Plumbing Fixtures. PLUMBING FIXTURES such as HANDWASHING SINKS, toilets, and urinals shall be cleaned as often as necessary to keep them clean. On 04/06/2026 at 12:25 PM observed several kitchen ceiling tiles adjacent to the ceiling vent soiled with dust build up. When mentioned following this observation, DM 'KK' indicated they would put in a maintenance request for cleaning of this area. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure treatment in a dignified manner for seven residents (R#'s 45, 50, 21, 32, 8, 18, and 60) of seven residents reviewed for dignity, resulting in verbalized complaints from the anonymous group interview and the potential for embarrassment. Findings include: 4/6/26 at 10:19 AM, CNA 'F' was observed transporting R45 to the shower room on the B-Wing via a shower chair. CNA 'F' was observed pulling the chair in a forward motion with R45 facing rearward. On 4/6/26 at 12:06 PM, an observation of the lunch meal in the Meadowbrook dining room was conducted. There were numerous residents seated at tables awaiting their meals to be served. At that time, it was also observed three staff, CNA 'C', CNA 'E', and Nurse 'G' were present in the room. The staff members were talking across the dining room amongst themselves about the resident's physical abilities to feed themselves and were repeatedly overheard to refer to some of the residents as, feeders. On 4/6/26 at 12:39 PM, CNA 'D' was in the dining room assisting with the lunch meal and was overheard to ask if a resident was a feeder. On 4/7/26 at 8:28 AM, an observation of the breakfast meal was conducted in the Meadowbrook dining room. At that time, CNA 'H' was observed providing one-to-one feeding assistance to R50. In between feeding R50 bites of food, CNA 'H' was observed to have a cell phone in their lap and was scrolling through the phone while providing the one-to-one feeding assistance. On 4/7/26 at 8:34 AM, R21 and R32 were observed in the dining room seated at an adjustable table. It was observed the table was in the lowest position with the height only reaching their knees. On 4/7/26 at 8:41 AM, Nurse 'I' was observed standing over R8 assisting them with their breakfast meal by guiding R8's hands from their plate to their mouth with their eating utensils. Nurse 'I' was overheard to say, There are no chairs in here. Nurse 'I' did not leave the room in an attempt to locate a chair, rather they continued to stand over R8 while they guided R8's hands to bring the food to their mouth for the duration of the meal. On 4/8/26 at 12:50 PM, an observation of the lunch meal was conducted. R18 and R60 were observed seated at an adjustable table. The table was at the lowest level and the height reached their knees. R18 was observed to be hunched over as they fed themselves their food from the table at their knee level. On 4/8/26 at 3:50 PM, an interview was conducted with the facility's Administrator regarding concerns with dignity. They indicated it was not appropriate to refer to residents as feeders and acknowledged the dignity concerns. A review of a facility provided policy titled, Resident Dignity & Personal Privacy revised 3/2024 was conducted and read, The facility provides care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy . On 4/7/26 at 1:11 PM, during an observation of the A Hall unit. An unknown staff member was (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. This citation pertains to Intake Number: 2563496. Based on observation, interview, and record review, the facility failed to promptly act on grievances expressed by resident council members affecting nine of 11 residents who attended the confidential resident council interview, resulting in ongoing, unresolved concerns. Findings include: A review of Resident Council Meeting Minutes from October 2025 through March 2026 revealed the following: On 3/25/26, 2/27/26, 1/30/26, and 11/20/25, it was documented in the minutes that residents had a concern with not receiving fresh water every day. On 3/25/26, it was documented in the minutes that residents had concerns with Certified Nursing Assistants (CNAs) splitting rooms, using phones during care, and telling residents they would be right back but did not come back.On 4/7/26 at 10:00 AM, an interview was conducted with 11 residents, all who frequently or sometimes attended the resident council meetings in the facility. When queried about how they expressed concerns to the facility in resident council and if the facility took steps to promptly resolve their concerns, nine of 11 residents in attendance indicated they had ongoing concerns that were not resolved. When queried about the unresolved concerns, the following was expressed: Nine of 11 residents reported they did not receive fresh water every day. One resident said it was a chronic problem. Another resident said they went a whole day without water. Another resident said when the nurses passed medications, at times they did not even have water to take their medications with other than the small cup the nurse brought. Multiple residents said they ask a CNA for water and because they split the room with another CNA (one CNA is assigned to a resident in the room and another CNA is assigned to their roommate), if they asked for water, the roommate's CNA said they were not their CNA and did not get them water. One resident said they are not given fresh water at night and if they ask the CNA, they said they would bring it but never came back. The resident reported that happened often, but most recently on Easter Sunday (4/5/26). Four of 11 residents reported they felt there was not enough staff to care for the residents. One resident said they changed CNAs to work 12-hour shifts instead of eight hours, but they got burned out and then they quit which leaves the facility short staffed. The same resident reported on the evening of Easter Sunday a nurse did not come in and another nurse had to cover the whole C unit. Another resident said nurses often have to cover multiple units. Three residents reported issues with other residents wandering into their rooms and said there was not enough staff to supervise them. One resident said the wandering resident sometimes take their belongings. When it was short staffed, the residents reported the CNAs will tell them they have to do other things before they can assist them and often times, they do not come back. One resident reported they were not provided incontinence care in a timely manner, most recently on Easter Sunday. They reported their brief was changed at 11:30 PM on 4/5/26, but not again until 4/6/26 at 3:00 PM when they were given a shower. Another resident said the staff do not return after answering the call light. Four residents reported staff talk on the phone while providing care to the residents. It was reported the staff wear ear buds and have personal phone conversations while providing care. Another resident reported staff have personal conversations loudly in the hallway. Multiple residents reported they had concerns with the cleanliness of their rooms and bathrooms. One resident said some housekeepers are better than others. Another resident said their bathroom was always dirty and they ended up cleaning it on their own. Another resident reported when they brought up housekeeping issues to the department head, they got angry and told them they were wrong. They said they did not bother going to the Administrator because issues were not resolved. On 4/8/26 at 8:53 AM, an interview was conducted with Activities Director (AD) 'S'. When queried about how concerns brought up in resident council were addressed, AD 'S' reported she wrote all concerns down, completed concern forms for each issue, and the concern forms went to the appropriate department head to address. The Administrator maintained a file with the concern forms and follow up. On 4/8/26 at 9:05 AM, an interview was conducted with the Administrator. When queried about how concerns expressed by the resident (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	council members were addressed and resolved, the Administrator reported she attended the resident council meetings. All concerns were documented on a concern form and given to the appropriate department head or manager to follow up. When queried about ongoing complaints such as not receiving fresh water daily, the Administrator reported she had to follow up with the DON. At that time, all concern forms associated with the resident council meeting minutes were requested. A review of Resident, Family, Employee, and Visitor Assistance Forms generated from the resident council concerns from meetings held October 2025 through March 2026 revealed:On 3/25/26, residents had concerns with Nurses - CNAs using phone/earbuds when giving care - all shifts - all units .Staff will answer call light and tell resident they will be right back and never return . It did not document when this occurred, whether it was an ongoing problem .No signature of who completed the form. Facility response was left blank. Action to be taken was left blank. Facility follow-up was left blank.An undated form indicated multiple residents had concerns with .Not giving ice water/continually. Need to ask - Some CNA will reply 'you are not my resident' . Don't understand split rooms/CNAs. It was documented the problems continually occurred and the Administrator, Activities Director, and DON knew about the problems. It was documented they were ongoing problems for months and the DON, Administrator, and Activities Director were contacted in the past. The Facility Response and Action Take was to educate the staff. The follow-up section was left blank. On 11/24/25, resident had the following concern, Residents stated they continue to have to ask for fresh ice water, afternoon midnights are majority of time/shift. It was documented it was a continual problem that was ongoing for couple months, and the DON, Administrator, and Activity Director were contacted in the past. The Facility Response section indicated the residents were asked if they were telling anyone at the time they were not getting water or waiting until the resident council meeting. The Action Taken section indicated staff were sent a message regarding fresh ice water and residents were asked to mention to the nurse if they did not receive water instead of waiting until the resident council meeting. The form was signed off by the Administrator on 12/5/25. A Sign-in sheet dated 10/25 indicated an in-service was provided Re: fresh water .Staff is to provide all residents excluding NPO (nothing by mouth) with fresh ice water daily q (every) shift. A new cup with shift and date must be given daily.No concern forms or documented action taken for concerns expressed during the January and February 2026 resident council meetings were received. During the survey, deficiencies were identified with not providing water daily, not having sufficient nursing staff, and not maintaining a clean environment. On 4/8/26 at 3:49 PM, an interview was conducted with the facility's Administrator regarding their QA (Quality Assurance) program. They were asked if they consistently documented resident and or family complaints and said they tried to handle them right at the time of occurrence but could probably do a better job with documenting the complaint, resolution, and satisfaction with the outcome. A review of a facility policy titled, Resident Council, last revised 12/23/2025, revealed, in part, the following, .The Resident Council grievances and recommendations will be documented on the Resident Assistance Form .The Completed forms are brought to the attention of the Administrator .and kept with the Resident Council minutes .Action taken and/or considerations given to issues will be reported back to the Resident Council at the following meeting and documented within the minutes . Cross-reference: F584, F725, F807

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and services according to professional standards of practice related to administering medications for two (R22 and R101) of two residents observed; failed to ensure diet orders were clarified and accurate for one (R98) of two resident reviewed for tube feeding; and failed to assess skin under an undated dressing for one (R96) of two residents reviewed for non-pressure skin conditions. Findings include:R22 and R101 On 4/6/26 at 9:42 AM, Licensed Practical Nurse (LPN) 'I' entered the room of R22 and R101 with both residents' medications. LPN 'I' first gave R101 her medications and then R22. On 4/6/26 at 2:20 PM, an interview was conducted with LPN 'I'. When queried about protocols for medication administration and whether multiple residents' medications should be prepared at the same time, LPN 'I' reported they were not supposed to be prepared at the same time, but she was just trying to get them done. On 4/7/26 at 12:15 PM, an interview was conducted with the Director of Nursing (DON). The DON reported nurses should not prepare medications for different residents at the same time. A review of R22's clinical record revealed R22 was admitted into the facility on [DATE] with diagnoses that included: hereditary spastic paraplegia and dementia. A review of R22's Minimum Data Set (MDS) assessment dated [DATE] indicated she had moderately impaired cognition. A review of R101's clinical record revealed R101 was admitted into the facility on 7/14/23 with diagnoses that included: history of a stroke and diabetes. A review of a MDS assessment dated [DATE] revealed R101 had intact cognition. R98 On 4/6/26 at 9:58 AM, R98 was observed lying in bed receiving nutrition through a feeding tube. A cup of orange juice was observed on the resident's over-bed table. A review of R98's clinical record revealed the following active physician's orders: Nothing By Mouth (NPO) diet Nothing By Mouth texture, Nothing By Mouth consistency, for Tube Feeding with a start date of 3/9/26. Regular diet Pureed texture, Thin consistency, 1:1 (one to one) assistance at all meals for Pleasure feeding with a start date of 3/11/26. On 4/7/26 at 8:48 AM, Certified Nursing Assistant (CNA) 'V' delivered a breakfast tray to R98 and placed the food in front of the resident and left the room. A cup of orange juice was also observed in front of the resident. At that time, R98's meal ticket was reviewed and it noted, pleasure tray 1:1 feed. A review of a Progress Note written by Nurse Practitioner (NP) 'II' revealed, .She was seen today to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow up on her eating status. Since returning from a recent hospitalization, the patient has been NPO .I was unable to find a note from the speech pathologist (SLP), and they were not present in the facility today to discuss the patient's condition. We will continue the current feeding regimen until the SLP evaluation and further recommendations are made .npo until further recommendation from SLP. (Speech Language Pathologist) . Review of an Interdisciplinary Therapy Screen dated 3/11/26 revealed R98 was screened for modified diets. The following was documented by SLP 'T': .spoke with PA (Physician Assistant), cleared to return to previous diet (pleasure tray, puree solids/thin liquids) 1:1 assist as needed for all meals . On 4/7/26 at 9:07 AM, an interview was conducted with LPN 'N', (Unit Manager) after they exited R98's room and put a straw in R98's cup of orange juice. LPN 'N' was queried about R98's diet and reported she received tube feeding with a pleasure tray. When queried about why there were active orders for NPO and food by mouth, LPN 'N' reported there should not be two orders. LPN 'N' said if there were two conflicting orders, they should have been clarified prior to serving food to R98. On 4/7/26 at 12:15PM, an interview was conducted with the Director of Nursing (DON). The DON reported the nurse should have contacted the dietician for clarification of R98's diet orders prior to serving her food by mouth. A review of R98's clinical record revealed R98 was admitted into the facility on 8/3/23 and readmitted on [DATE] with diagnoses that included: sarcoidosis and dysphagia (difficulty swallowing). A review of a MDS assessment dated [DATE] revealed R98 had moderately impaired cognition. A review of a facility policy titled, Medication Administration, last revised on 10/17/23, revealed, in part, the following, .Follow safe preparation practices . R96 On 4/6/26 at 10:27 AM, R96 was observed sitting in a wheelchair in the activity room, an undated dressing was observed on R96's right forearm. R96 was asked what the dressing was. R96 explained he did not know but he had another one on his left forearm. R96's left forearm was observed to have an undated dressing that had bruising visible underneath the dressing. Review of the clinical record revealed R96 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: peripheral vascular disease, heart disease and dementia. According to the Minimum Data Set [MDS] assessment dated [DATE], R96 had moderately impaired cognition. Review of R96's physician orders revealed no order for any dressings. On 4/7/26 at 9:55 AM, R96 was observed sitting in a wheelchair in the hallway. Both undated dressings on the right and left forearms appeared to be the same dressing. On 4/7/26 at 11:39 AM, observation of R96's dressings was made with the DON. The DON removed both dressings and explained they both appeared to be from a blood draw. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/7/26 at 11:44 AM, the DON was asked when was the last time R96 had blood drawn at the facility. The DON explained the last blood draw was on 12/23/25, but R96 had been readmitted from the hospital on 4/2/26 and the dressings most likely had been put on at the hospital. The DON was asked if R96 should still have any dressing he had gotten at the hospital prior to readmission. The DON explained no, her expectation was for the nurse to remove the dressing to see what was under the dressing and assess the skin. Review of a facility policy titled, Standards of Nursing Practice revised 3/12/25 read in part, .The delivery of nursing care in the facility is based on a thorough evaluation of the resident to identify his or her care needs. The nurse collects data regarding the resident's current health status and potential risk areas. Data is obtained through direct resident evaluation and health history, as well as interaction with family members and other health care providers.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Novi	24500 Meadowbrook Rd Novi, MI 48375

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to identify, assess, implement treatment, and follow physician's orders for treatment and preventative care for one (R32) of two residents reviewed for non-pressure skin conditions, resulting in the development of 10 open areas to the resident's left lower leg and a delay in treatment. Findings include: On 4/6/26 at 10:01 AM, R32 was observed seated in a geriatric positioning recliner (geri-chair). R32 was awake but did not make eye contact or engage in conversation. R32 was observed kicking their left leg straight up into the air and then forcefully back down onto the footrest of the geri-chair repeatedly. Five pink colored open areas were observed on the top of R32's left lower leg with no dressing applied. A review of R32's clinical record revealed an active physician's order to clean left shin with NS (normal saline), pat dry, cover with border gauze and Tubi grip (elastic bandage) to bilateral legs, remove tubi grip and check skin integrity q shift. On 4/6/26 at approximately 2:20 PM, a dressing was observed on R32's left lower leg dated 4/6/26. R32 was observed kicking their left leg up and down. No elastic bandage was observed on R32's legs. A review of R32's progress notes revealed the following: A Skin Check progress note dated 3/28/26 indicated no new skin issues for R32. A Nurses Notes progress note dated 3/30/26 noted, writer observed skin tear on res (resident) left shin .hospice nurse rounded, cleaned, covered, and placed orders for skin tear. DON (Director of Nursing), hospice nurse and responsible party notified. A Nurses Notes progress note dated 4/1/26 noted, IDT (Interdisciplinary Team) met to discuss the skin tear. The resident was observed with a skin tear to her left shin. The resident was sitting in her wheelchair when the area was observed. The area was cleansed and dressed. Intervention apply (elastic bandage) to bilateral legs. On 4/6/26 at 1:00 PM, a further review of R32's progress notes revealed no documented assessment of R32's skin tear to the left lower leg. There was no documentation of any additional open areas to R32's left lower leg. A review of assessments in R32's clinical record revealed no assessment form that documented R32's skin tear or any other open areas. On 4/7/26 at 1:04 PM, the DON was asked to provide a staff member who was able to assess wounds to conduct an observation of R32. An observation of R32's left lower leg was conducted with Unit Manager, Licensed Practical Nurse (LPN) 'N'. R32's left lower leg was observed with a large adhesive dressing dated 4/6/26. LPN 'N' reported she was not wound care certified. LPN 'N' brought wound care supplies into R32's room, including split gauze (typically used for tube feeding sites) and smaller adhesive dressings. LPN 'N' reported she thought the dressing that was applied to R32's left lower leg was too much for a skin tear. No elastic bandages were observed on R32's bilateral legs. LPN 'N' removed the adhesive dressing. Multiple areas of dried brown drainage were observed on the dressing with one area that had medicated gauze dressing stuck to it. LPN 'N' said the dried drained looked like dried blood. After the dressing was removed, multiple open areas were observed on the top and back of R32's left lower leg. When LPN 'N' was asked about the multiple open areas, LPN 'N' stated, I thought there was just a skin tear. At that time, LPN 'N' left the room to obtain a nurse to assess wounds. On 4/7/26, an observation of R32's left lower leg was conducted with Infection Control Preventionist, Registered Nurse (RN) 'R'. RN 'R' was asked to assess (including measurements) all open areas to R32's left lower leg. RN 'R' stated, Wounds are not really my thing and proceeded with the assessment. The following 10 open areas were observed to R32's left lower leg: Top of R32's left lower [NAME] circular open area with a pink center with grey colored macerated rolled edges that measured (according to RN 'R') 1 centimeter (cm) by (x) 1 cmA circular open area with a pink center with grey colored macerated rolled edges that measured 1 cm x 1 cmAn open area pink in color that measured 0.5 cm x 0.5 cmAn open area pink in color that measured 0.5 cm x 0.3 cmA dry closed areaBack of R32's left lower [NAME] open area that RN 'N' described as a dry area that measured 1 cm x 5 cmA dry area open in the center with discolored surrounding skin as described by RN 'N' that measured 1 cm x 1 cmThree additional open areas that were not described or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measuredOn 4/7/26 at 2:01 PM, an interview was conducted with the DON. When queried about the facility's protocol when new skin impairments were identified, the DON reported if a resident had a new skin tear, they would open a risk management (incident report), notify all parties, discuss with the IDT, and put a treatment in place. When queried about who was responsible to assess the wound upon identification, the DON reported the treatment nurse was responsible to take a picture of the wound and the outside wound team would assess the wound the next time they were in the building. When queried about the number of open areas observed on R32's left lower leg and the lack of documented assessment of the initial skin tear and any other open areas, the DON reported a wound consult should have been done on 3/31/26 and the treatment nurse (LPN 'M') should have taken a picture. The DON reported the wound providers evaluated all skin impairments including skin tears. Residents who received hospice services were evaluated by the wound provider for new skin impairments and monthly thereafter. The DON reviewed R32's clinical record at that time and confirmed R32's skin tear was not assessed or evaluated by the wound provider and the additional open areas were not identified or assessed. At that time the DON reviewed the hospice documentation for R32 and revealed a document titled Physicians Order dated 4/6/26. The document noted, Pt (patient) has skin tear to L lower leg, but did not include any assessment of the skin tear or any other open areas. A review of a hospice Visit Log entry dated 3/30/26 revealed, .New skin tear to LLE (left lower extremity) anterior (top) wound care orders and care done . There was no documented assessment of the skin tear or any additional open areas. A review of incident report dated 3/30/26 for Skin Tear revealed, .writer observed ski [sic] tears on res L (left) shin area .Hospice nurse cleaned, and covered area. Treatment orders placed. Tubi grip to bilateral legs . The incident report indicated there were more than one area on the left lower leg as indicated by skin tears (plural). Further review of R32's progress notes on 4/8/26 at approximately 8:30 AM revealed a note from RN 'R' that documented, .Multiple wounds noted to left lower leg. Wound measures approximately 1.0 x 1.0 (cm) with granulation present to wound bed. Surrounding skin is CDI (clean dry and intact), and discoloration is present . The progress note did not indicate which wound was assessed per the documentation, did not include the description of the macerated rolled edges observed on two or the wounds on the top of the leg, or assessments of each open area that was present on R32's leg. On 4/8/26 at approximately 1:13 PM, an interview was conducted with the DON. The observation of R32 not having the elastic bandages applied to their bilateral legs on 4/6/26 and 4/7/26 during all observations, the DON reported the physician's orders should have been followed.Further review of R32's clinical record revealed R32 was admitted into the facility on 3/23/20 and readmitted on [DATE] after a hospitalization. R32's diagnoses included: Alzheimer's disease, protein-calorie malnutrition, unspecified convulsions, and anoxic brain damage. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R32 had severely impaired cognition and was dependent on staff for all activities of daily living. A review of R32's care plans on 4/6/26 at approximately 2:00 PM revealed a care plan initiated on 3/23/20 that read, .at risk for skin integrity .R/T (related to) .vigorously kicks left leg at times . Interventions included: Tubi grip to bilateral legs (initiated on 3/31/26).On 4/8/26 at approximately 3:45 PM, an interview was conducted with LPN 'M', the treatment nurse for the facility. LPN 'M' reported she did rounds with the wound provider and took pictures of wounds when she was notified of new skin impairments. When queried about R32's skin tear and other open areas to the left lower leg, LPN 'M' reported she was told by corporate staff not to take pictures of skin tears. LPN 'M' confirmed she did not look at R32's left lower leg. On 4/8/26 at approximately 3:50 PM, an interview with the DON was conducted. The DON reported LPN 'M' was supposed to take pictures of R32's skin tears which contradicted what LPN 'M' reported. A review of a facility policy titled, Skin Management, last revised 1/28/26, revealed, in part, the following, .Upon occurrence, all skin tears will be reported to the licensed nurse .An Incident and Accident Report is to be completed .The licensed nurse is responsible for documenting skin tears upon occurrence and monitoring on a weekly basis until healed .Photos of skin tears are not required .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 a resident received needed pain and antibiotic medication for an infected tooth for one (R8) out of two residents reviewed for dental/pain services resulting in continuous pain for over one month. Findings include:On 4/6/26 at approximately 10:15 AM, R8 was observed sitting in their wheelchair, food covered their shirt. R8 was alert and able to answer most questions asked, however their speech was slurred at times. R8 reported that they were in pain. The resident was asked if they wanted to see a nurse and they noted they did. The resident's call light was out of reach and Nurse CC was told that the resident reported they were in pain. A review of R8's clinical record revealed they initially were admitted to the facility on [DATE] with diagnoses that included: DiGeorge Syndrome (a complex gene disorder), severe depressive disorder, and bacterial infection. A review of R8's most recent Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 (intact cognition). Continued review of R8's clinical record revealed the following:3/3/26: Progress Note: .Patient seen today at the request of social worker for evaluation of tooth pain. The patient reported that the pain in his right bottom tooth started three days ago and has worsened since then.The patient will be scheduled for a follow-up appointment with the dentist and will be started on Augmentin (antibiotic) 875 mg (milligrams) two times daily for a suspected tooth abscess. Continuous monitoring is recommended, and the provider should be notified if the patient's condition worsens.3/3/26: eMAR (electric Medication Administration Note): .Amoxicillin.875 mg.give 1 tablet every 12 hours for Tooth infection for 7 days.3/9/26: eMAR: .patient c/o (complains of) pain.3/19/26: Encounter: .Nursing reports resident refused dinner c/o jaw pain.3/20/26: Dental Group: .Clinical exam completed at bedside.resident has plaque and calculus build up.recommend cleaning every 6 months. Patient cc (chief complaint) dental pain on lower right. States he is ?unable to open all the way'. Exam.decayed.recommend dental extraction and course of abx 500 mg (milligrams) TID (three times per day) for 10 days.Refer to Oral Surgeon.3/21/26: Infection Note: Amoxicillin 500 mg .give 1 tablet by mouth three times a day for dental infection to lower right for 10 days.medication on order.3/22/26: eMar: Med (amoxicillin) not available.on order.3/25/26; Progress Notes: .Resident was complaining of toothache. Will order.Norco (opioid used for pain) 5-325 every 6 hours as needed for 14 days.continue monitoring resident closely.3/25/26: Order: .Hydrocodone-Acetaminophen oral 5-325 MG.Give 1 tablet by mouth every 6 hours as needed for pain for 14 days.3/26/26: Social Service Note: (R8) was seen by.Dental on 3/20/26 with c/o tooth/mouth pain.Called (name redacted) Dental.Dental could not accept (R8) because of transfer status.3/29/26: Hospital Records: .Medical Information: Diagnosis: Dental cavities.Instruction Given: Dental Pain.4/3/26: Progress Note: .was recently hospitalized for a pulmonary embolism.and a odontogenic infection (bacterial infection originated by teeth.4/6/26: eMar: 10/10 tooth pain. Resident request pain medication for relief.4/7/26: eMAR: 10/10 tooth pain.4/7/26: Pain Interview: .Should pain Assessment Interview be Conducted: Yes.Have you had pain or hurting at any time in the last 5 days: Yes.Pain Frequency: Almost always.Please rate your worse pain in the last 5 days .ten as the worst.Enter.response: 10.has mouth/tough pain.A review of R8's Medication Administration Record (MAR) for March 2026 and April 2026 noted the following:The order for 7 days of Amoxicillin 675 MG (give 2 times per day) with a start date of 3/3/26 was not provided on 3/3/26 (9PM) or on 3/10/26 (9M) indicating the resident received only six days of the antibiotic.The order for 10 days of Amoxicillin 500 MG (give 3 times per day) with a start date of 3/20/26 was not administered on 3/20/26 (x2) and 3/21/26 (x3).The MAR for April 2026 noted that on 4/6/26 and 4/7/26, R8 had a pain level of 10/10 and was given ibuprofen. There were no notes indicating the physician was contacted regarding excessive pain.On 4/8/26 at approximately 9:42 AM, an interview was conducted with Social Work Director (SW) B. SW B was asked about ancillary dental services and noted that dental services are generally in the building monthly. SW B (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was asked about R8's dental pain concerns and when would the resident receive the extraction recommended by dental services on 3/20/26. SW B noted that they were having difficulty scheduling the extraction based on the resident's insurance but indicated that they were scheduled to receive an x-ray on or about 4/9/26, but the extraction would not be completed until after the x-ray was completed.On 4/8/26 at approximately 12:06 PM, R8 was observed sitting in their wheelchair. The resident was asked about their tooth and reported that they were in pain and pointed to their lower left jaw area. R8 was asked if they needed assistance and noted that they did. The resident's call light was on the other side of their bed, and the resident could not push the call light for assistance. R8 noted that they believed staffing purposely does not put their light within reach.On 4/8/26 at approximately 3:54 PM, an interview and record review were conducted with the Director of Nursing (DON). The DON was queried as to R8's tooth pain/infection that started on or about 3/3/26. The DON reported that they were aware of the situation. The DON was asked about the missing doses of the antibiotic ordered for R8's infected tooth. The DON reported that they could not understand why the resident did not receive the antibiotics as the medication should have been in back-up. The DON was asked why the resident's order for Hydrocodone-Acetaminophen oral 5-325 MG was discontinued despite the fact that the resident continued to have pain caused by their tooth infection and reported 10/10 pain on 4/6/26 and 4/7/26. The DON reported that they were not sure, believed it may have been discontinued when the resident returned from the hospital on 4/3/26. However, they could not provide any further information as to why the physician was not contacted regarding the high pain levels.The facility policy titled, Pain Management (3/5/25) was reviewed and documented, the following: .The facility will evaluate and identify residents for pain, determine the type, location and severity.Subacute pain refers to pain that has been present for 1-3 months.residents will be monitored for the presence of pain when there is a change in condition and whenever new pain or an exacerbation of pain is suspected.follow the pain evaluation notify the physician if indicated and implement new orders as received.Nurse will communicate any new onset of resident pain or change in pain to the physician.Prescribing practitioners may find that opioid mediations are the most appropriate treatment for.subacute pain.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intakes 2563496 and 2748674Based on interview and record review, the facility failed to ensure medications were acquired and administered per physician orders for one [R96] of four residents reviewed for medication administration. Findings include:Review of the clinical record revealed R96 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: peripheral vascular disease, heart disease and dementia. According to the Minimum Data Set [MDS] assessment dated [DATE], R96 had moderately impaired cognition.Review of R96's progress notes revealed multiple Medication Administration Notes dated 4/2/26, 4/3/26, 4/4/26, 4/5/26 that documented Pregabalin [medication used for nerve pain] 100 milligrams [mg] was on order and waiting for the pharmacy to deliver.Review of physician orders for R96 revealed an order dated 4/2/26 for, Pregbalin Oral Capsule 100 MG. Give 1 capsule by mouth at bedtime for Neuropathy. Active. Start Date: 4/2/26.Review of R96's April Medication Administration Record [MAR] revealed R96 did not receive the Pregbalin 100 mg on 4/2/26, 4/3/26, 4/4/26 and 4/5/26.On 4/7/26 at 11:39 AM, the Director of Nursing [DON] was interviewed and asked why R96 had not received their Pregbalin since they had been readmitted . The DON explained she had not known R96 had not received their medication. The DON was asked if she used medication audits to ensure all medication were given. The DON explained she did not run audits; she relied on the Unit Managers to give reports in the Morning Meetings from their review of progress notes. The DON was asked if R96's Pregbalin had been brought up in the Morning Meetings. The DON explained they had not had a Morning Meeting since 4/2/26. The DON was asked what should the nurses have done when the Pregbalin was not available. The DON explained they should have contacted the pharmacy and the physician. The DON was asked if Pregbalin 100 mg was available in the back-up medication supply. The DON explained she was not sure but would find out.Review of a list of medications available in the facility's back-up supply included six capsules of Pregbalin 100 mg.On 4/8/26 at 9:33 AM, the DON was asked if Pregbalin 100 mg was available in the back-up supply, why did R96 not receive their medication. The DON explained the nurses should have pulled the medication from the back-up until the medication came from the pharmacy.Review of a facility policy titled, Medication Administration revised 10/17/23 read in part, .Medications are administered in accordance with written orders of the attending physician. Begin new medications orders timely.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure fresh water was passed and available to residents consistently and upon request for four (R4, R22, R79, R101) of four residents reviewed for hydration. Findings include: On 4/6/26 at 9:30 AM, R101 and R22 (who were roommates) were observed with Styrofoam cups dated 4/5/26 7:00 AM to 7:00 PM. Both residents indicated water was last passed on the morning of 4/5/26 and not passed since then (24 hours later). On 4/6/26 at 10:04 AM, R79 was observed with a Styrofoam water cup dated 4/5/26 7:00 AM to 7:00 PM. When queried about whether she had fresh water, R79 shook the cup which was empty and said nobody passed fresh water since Sunday morning (4/5/26). On 4/7/26 at 10:00 AM, an interview was conducted with 11 residents who wished to remain anonymous. Nine of 11 residents reported they did not receive fresh water every day. One resident said it was a chronic problem. Another resident said they went a whole day without water. Multiple residents said they ask a CNA for water and because they split the room with another CNA (one CNA is assigned to a resident in the room and another CNA is assigned to their roommate), if they asked for water, the roommate's CNA said they were not their CNA and did not get them water. One resident said they are not given fresh water at night and if they ask the CNA, they said they would bring it but never came back. The resident reported that happened often, but most recently on Easter Sunday (4/5/26). A review of Resident Council Meeting Minutes from October 2025 through March 2026 revealed the following: On 3/25/26, 2/27/26, 1/30/26, and 11/20/25, it was documented in the minutes that residents had a concern with not receiving fresh water every day. On 4/7/26 at 12:15 PM, an interview was conducted with the Director of Nursing (DON). When queried about the facility's protocol to ensure residents were provided with enough fresh water throughout the day and per their request, the DON reported water is passed each 12 hour shift with no specific time during that shift that it was required to be passed by. When queried about whether one water pass a day provided sufficient fluid for residents, the DON reported staff should provide water upon request or if they noticed the cups were empty. The DON was not aware of water not being passed on 4/5/26 after the first shift on the A Hall. A review of R101's clinical record revealed R101 was admitted into the facility on 7/14/23 with diagnoses that included: history of a stroke and diabetes. A review of a MDS assessment dated [DATE] revealed R101 had intact cognition. A review of R79's clinical record revealed R79 was admitted into the facility on [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease. A review of a MDS assessment dated [DATE] revealed R79 had moderately impaired cognition. R4 (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed R4 was admitted to facility on 3/12/26 for osteomyelitis (infection in the bone) of the left foot requiring amputation of the toes and required administration of intravenous (IV) antibiotics via PICC (Peripheral Inserted Central Catheter) line, had Acute Kidney Injury (AKI) due to kidney failure and required hemodialysis. R4 was alert, orientated, and capable of making their needs known. Minimum Data Set, dated [DATE] documented .Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Set up or clean-up assistance and no impairment with upper range of motion. On 4/6/26 around 10:30 AM, during initial introductions, R4 voiced concern on Easter Sunday 4/5/26, they had requested a glass of water four to five times and never received anything to drink until today 4/6//26. R4 was concerned because they were having concerns with urinating, knew they had to drink more, and was never provided water.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the residents call light was within reach for one (R8) out of one resident reviewed for call light status. Findings includeOn 4/6/26 at approximately 10:15 AM, R8 was observed sitting in their wheelchair, food covered their shirt. R5 was alert and able to answer most questions asked. R8 reported that they were in pain. The resident was asked if they wanted to see a nurse and they noted they did. The resident's call light was out of reach and Nurse CC was told that the resident reported they were in pain. On 4/8/26 at approximately 12:06 PM, R8 was observed sitting in their wheelchair. The resident was asked how they were feeling and reported that they were in pain and pointed to their lower left jaw area. R8 was asked if they needed assistance and noted that they did. The resident's call light was on the other side of their bed, and the resident could not push the call light for assistance. R8 noted that they believed staffing purposely does not put their light within reach. A Certified Nursing Assistant (CNA) was told the resident's call light was out of reach and they noted they had to complete something but would put it back after they completed care.A review of R8's clinical record revealed they initially were admitted to the facility on [DATE] with diagnoses that included: DiGeorge Syndrome (a complex gene disorder), severe depressive disorder, and bacterial infection. A review of R8's most recent Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 (intact cognition). On 4/8/26 at approximately 4:00 PM, the Director of Nursing (DON) was interviewed about R8's dental concerns. During the interview the DON was informed as to R8's call light being out of reach and noted that staff should ensure call lights are in reach.

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The Manor of Novi	24500 Meadowbrook Rd Novi, MI 48375

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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 maintain a clean, comfortable, and homelike environment for two (R79 and R98) of four residents reviewed for the environment, resulting in R79 having to clean their own bathroom at times and R98 expressing frustration with a non-working clock. Findings include: On 4/6/26 at 9:58 AM, R98 was observed lying in bed. At that time, an interview was conducted with the resident. R98 answered mostly with yes and no answers but appeared to understand the questions asked. The clock on the wall at the foot of R98s bed read 8:50 with the second hand staying in the same position. A second observation was made at 2:20 PM and the clock read the same time, 8:50. On 4/7/26 at 1:06 PM, an observation of R98's clock was made and it remained at 8:50. An interview was conducted with R98. When queried about whether she was able to read the clock, R98 nodded her head and said Yes. When queried about whether it was important for her to know the actual time, R98 nodded her head and stated, Yes. On 4/6/26 at 10:04 AM, R79 was observed seated in a wheelchair in her room. At that time R79 was interviewed about any concerns she had. R79 reported it took a long time for her room and bathroom to be cleaned. R79 reported when it was addressed with the staff, they had attitudes, but it's their job. R79 reported she often had to make her own bed and clean the bathroom. R79 reported the resident in the adjoining room sometimes left soiled briefs with feces, urine, and menstrual blood on the floor, the toilet was often dirty, and the trash was not emptied regularly. R79 said she had her own cleaning supplies and sometimes put gloves on and picked up the dirty briefs and wiped down the bathroom. At that time, an observation of R79's bathroom was conducted. A urinal was observed hung behind the toilet with dried brown substance caked on the bottom. R79 said the urinal was in the bathroom for a long time and did not understand why they left it in there. The trash can was observed full to the top with soiled briefs with visible fecal matter. The toilet was observed with a dried brown substance on the outside, front part of the toilet. R79 reported they typically emptied the trash cans daily, but it took a while and stated, Some people clean better than others. On 4/6/26 at 2:20 PM, R79's bathroom remained in the same condition as mentioned above. On 4/8/26 at 4:09 PM, an interview was conducted with Housekeeping Supervisor (HS) 'P'. HS 'P' reported housekeeping services are provided by housekeeping staff daily from 7:00 AM until 3:00 PM. From 3:00 PM until 7:00 AM, there was no housekeeping staff onsite, but they left supplies in each soiled utility closet for nursing staff to utilize, if needed. HS 'P' stated, Everyone is responsible to ensure a clean environment. When queried about the observation of R79's bathroom on 4/6/26 remaining unclean between 10:04 AM and 2:20 PM, HS 'P' reported the housekeepers had until 3:00 PM to get their cleaning done. When queried about whether a resident's bathroom remaining in an unclean condition for almost 24 hours was acceptable, HS 'P' stated, I don't understand what you are getting at. HS 'P' reported nursing staff were responsible to clean and/or remove urinals from resident rooms. On 4/8/26 at 4:14 PM, an interview was conducted with the Administrator. The Administrator reported all staff were responsible to ensure a clean environment. When queried about R98's clock, the Administrator reported clocks should be in working order. A review of R98's clinical record revealed R98 was admitted into the facility on 8/3/23 and readmitted on [DATE] with a diagnosis of sarcoidosis. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R98 had clear speech, made herself understood, had clear comprehension of others, and had moderately impaired decision-making ability. A review of R79's clinical record revealed R79 was admitted into the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease. A review of a MDS assessment dated [DATE] revealed R79 had moderately impaired cognition. A review of a facility policy titled, Federal & State - Resident Rights & Facility Responsibilities, last revised 5/14/2024, revealed, in part, the following, .The resident has a right to a safe, clean, comfortable and homelike (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment .Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to release a seatbelt restraint during supervised activities and supervised dining and document the removal of the restraint every two hours per the physician's order for one resident, (R60) of two residents reviewed for restraints. Findings include: On 4/6/26 at 10:25 AM, R60 was observed in their room in their wheelchair with a seatbelt across their waist. At that time, R60 was asked if they could unbuckle the belt and they did not answer the question or attempt to release the belt, rather they pleasantly chatted about an unrelated topic. On 4/7/26 at 2:58 PM, R60 was observed in the activity room seated in their wheelchair with their seatbelt fastened across their waist. Staff were observed to be present in the room during the scheduled music activity. On 4/8/26 at 12:50 PM, R60 was observed in the dining room in their wheelchair eating their lunch meal. It was noted their seatbelt was fastened across their waist. Several staff were present in the dining room providing assistance to other residents. A review of R60's clinical record revealed they most recently admitted to the facility on [DATE] with diagnoses that included: diabetes, chronic kidney disease, dementia, depression, and anxiety disorder. A review of R60's physician's orders was conducted and revealed an order dated 8/24/24 that read, SEATBELT RESTRAINT DX (Diagnosis): Repeated falls and muscle weakness release seatbelt q (every) 2 hours and with supervised activities . R60's care plan for the use of the seatbelt restraint was reviewed and read, .Interventions .Document device use and release per facility protocol .Release and reposition q2 hours, with supervised meals, supervised activities and with toileting . On 4/7/26 at approximately 1:30 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding staff documentation for the release of R60's seatbelt every two hours, and with supervised meals and activities. The DON reported the facility did not have a place to document the release of restraints. A review of a facility provided policy titled, Restraint Management, revised 5/2025 was conducted and read, .7. During the time a restraint is in place, the restraint is periodically removed that the guest/resident assisted with change of position, range of motion, and/or stretching. Restraints should always be removed during supervised mealtimes and activities unless clinical contraindications are documented .

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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** This citation pertains to Intake 2789175.Based on record review and interview, the facility failed to complete a thorough investigation of alleged mistreatment for one of one resident (R106) reviewed for injury of unknown origin. Findings include:Findings include:Clinical record review revealed R106 was originally admitted to the facility on [DATE] with most recent re-admission on [DATE] and had medical history of diabetes managed with insulin, End Stage Renal Disease (ESRD) and required hemodialysis. R106 was physically compromised and required a Hoyer Lift (mechanical device to transfer an induvial with limited mobility). R106 Minimum Data Set (MDS) assessed on 1/15/2026 documented a Brief Interview Mental Status (BIMS) 13/15 indicating no cognitive impairment.On 4/6/26 at 1:25 PM, a telephone interview with the spouse (complainant) alleged on Super Bowl Sunday 2/8/26, The spouse said a nurse over the weekend called them reporting the injury and that I&A (Investigation and Accident) form had to be completed. Per the spouse R106 was verbally challenged by a Certified Nurse Assistant (CNA) early in the morning they needed to get up and dressed. It was alleged the CNA had transferred R106 via a Hoyer Lift and the improper transfer resulted in R106 sustaining skin tears to their neck and head.On 4/8/26 an Interview with Wound Care Nurse LPN M recalled on Monday 2/9/26, R106's spouse came to them around 6:00 PM asking if they knew about the new skin tears that occurred over the weekend from improper transfer with a Hoyer. Per LPN M they do not follow skin tears as part of their wound rounding but was familiar with R106 and kindly went down to observe the injuries. LPN M recalled a bandage covered the left side of R106's neck and thought there was maybe another tear on their left side of their forehead. LPN M stated she observed a moderate sized skin tear on left side of neck and another smaller skin tear on left side of forehead. Per LPN M the observations were not documented because they were instructed by Corporate not to follow skin tears. When asked if R106 was a good historian, they replied Oh yes.A Record review of the Nurses Notes dated 2/8/26 8:24 AM by LPN L documented .Nurse over heard <sic> resident yelling in room.Nurse went into the room to ensure everything was okay in which the aide explained that she explained to the resident that he was on the get up list but did not want to get out of bed. Aide stated that she informed him that was fine but she would help him put his clothes on and put Hoyer pad underneath him so when he was ready he'd be ready. Resident stated that he told aide no to getting up and getting dressed stated that he didn't want to get out of bed until 0930, also that they aide did not listen to him when he stated these thing and still got him dressed. Open areas found on left side of body, when res was informed of said open areas he requested for her to be removed from his care in the future, DON <sic> notified.On 4/8/26 at 3:05 PM a telephone interview with LPN L recalled the event with R106 and said there was arguing back and forth between CNA O and R106 and R106 said the O was not listening to them and did not want to get up. CNA O said they were on the get up list and they were just doing their job. LPN L told CNA O to just leave him alone. LPN L recalled they observed a skin tear on R106's neck, arm, and a third area but could not recall where. LPN L asked R106 what happened and said it must have been from the Hoyer sling being pulled up from under them. When LPN L asked what they believed caused the skin tears, LPN L replied it looked like it could have been from the Hoyer sling but could not confirm because they were not witness to the injuries. LPN L said they cleaned up the areas and then applied a triple antibiotic ointment and called the Director of Nursing (DON) and called R106's spouse as a courtesy even though R106 was their own person.On 4/8/26 at 3:55 PM, CNA O was telephoned for an interview, with no response by the end of this investigation.On 4/8/26 at 3:40 PM, An interview with the Nursing Home Administrator (NHA) and DON was conducted to review a Progress Note from 2/9/26 at 21:50 Documented as a Late Entry by the DON.The DON documented the IDT (Interdisciplinary Team) to discuss skin tears. The DON was asked what was discussed, and with whom? Did they speak to LPN L and CNA O and R106 as part of a debrief to get the entire story, and the DON denied having a formal (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussion. When asked if the CNA had any education on the incident, the DON acknowledged the nurses who report on the I&A are to provide the education.The DON documented the resident was observed with a skin tear to their neck. When asked why the neck was only identified as the injury even though the I&A completed by LPN L documented Injuries post incident: Left elbow, Left hand (back), back of head, all injury types .Unable to determine. The DON had no comment.When asked how the skin tears developed, The DON said from the Hoyer. When asked how they came to this conclusion they replied it was just assumed because the resident has fragile skin and it must have happened in the process.The DON documented .Areas were cleansed and dressed. when questioned what the cleaning and dressing treatment was, the DON had no response.The DON documented .Intervention two staff present during care. when asked what this meant, the DON said this was the intervention, so staff have witnesses when residents refuse care.Record Review of the I&A dated 2/8/26 did not address predisposing environmental factors, physiological factors, and situation factors.The NHA and DON were provided with an opportunity to forward any further documentation on R106's incident from 2/8/26 and no further records were offered. The NHA and DON acknowledged the concern the incident of the injuries was not thoroughly investigated. On 4/8/26 at Record Review of a Late Entry Progress Note from 2/9/26 at 21:50 authored by the DON documented that the Interdictipliary Team (IDT) met to discuss skin tears on a skin tear to the neck.IDT met to discuss skin tears. The resident was observed with a skin tear to his neck. The resident was on the assignment sheet as a midnight get and the cna approached to get the resident dressed and up. Per the cna the resident stated he didn't want to get up but he would get dressed. Resident then changed his mind regarding getting dressed. Resident transfers via hoyer lift and sling was put underneath the resident; the sling was removed. The resident has fragile skin and a skin tear happened in the process. Areas were cleansed and dressed. Intervention two staff present during care. Working the night shift was arguing back and forth she wasn't listening he get up list was she left out the room-[NAME] did not want to get up-I asked CNA [NAME] told her to let him be leave him alone-Acording to the DON this was the CAN's education-Nurses involved are OK to educate the CNAPer LPN-Skin tear on his neck, arm and third area, cannot remember-said the CNA pulled the hoyer under him LPN [NAME] saw it and [NAME] he got it from pulling it up-I then provided treatment at the time I cleaned it up with triple abx-multiple skin tears from fragile-based on the how the wounds look, it appeared to be from the or looked like could have been from the hoyer-reposiioned from underneath maybe when they were resoitoned.[NAME] was yelling unable to recall along the lines not wanting to get up-after she left hey I don't want to get she is not listeningI am just doing my job per the CNAHe is own person-I made a note of it Called [NAME] (DON) at Home.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist one (R98) of three residents reviewed for activities of daily with oral hygiene and feeding assistance. Findings include:On 4/6/26 at 9:58 AM, R98 was observed lying in bed receiving nutrition through a feeding tube. A cup of orange juice was observed on the resident's over-bed table with a straw. When R98 opened their mouth, a copious amount of thick, stringy, white substance was observed extending from the top of R98's mouth to the bottom. When queried, R98 reported staff did not often assist with brushing their teeth. When queried about their preference, R98 reported they would like their mouth cleaned and teeth brushed. A review of R98's clinical record revealed the following active physician's orders: Regular diet Pureed texture, Thin consistency, 1:1 (one to one) assistance at all meals for Pleasure feeding with a start date of 3/11/26. On 4/7/26 at 8:48 AM, Certified Nursing Assistant (CNA) 'V' delivered a breakfast tray to R98 and placed the food in front of the resident and left the room. A cup of orange juice was also observed in front of the resident. At that time, R98's meal ticket was reviewed and it noted, pleasure tray 1:1 feed. A review of an Interdisciplinary Therapy Screen dated 3/11/26 revealed R98 was screened for modified diets. The following was documented by Speech/Language Pathologist (SLP) 'T': .spoke with PA (Physician Assistant), cleared to return to previous diet (pleasure tray, puree solids/thin liquids) 1:1 assist as needed for all meals . Further review of R98's clinical record revealed the resident's care plan was not updated to include the new intervention for 1:1 assist at meals. An intervention initiated on 2/13/26 indicated R98 required supervision/touching assist with one helper. However, that was prior to the SLP screen conducted on 3/11/26. A review of the Kardex (CNA care guide) did not include instructions to provide 1:1 feeding assistance to R98. A review of a care plan initiated on 5/15/25 revealed, (R98) is at risk for infection, pain or bleeding in the oral cavity: has oral/dental health problems . Documented interventions included, Provide/assist/encourage oral hygiene, set up and assist with brushing. On 4/7/26 at 12:15PM, an interview was conducted with the Director of Nursing (DON). The DON reported the CNA should have stayed with the resident to provide feeding assistance. When queried about when staff were to assist residents with oral hygiene, the DON reported oral care was performed when getting the residents up in the morning and when lying them down at night. The DON reported oral hygiene was also performed when visibly needed. A review of R98's clinical record revealed R98 was admitted into the facility on 8/3/23 and readmitted on [DATE] with diagnoses that included: sarcoidosis and dysphagia (difficulty swallowing). A review of a MDS assessment dated [DATE] revealed R98 had moderately impaired cognition and was dependent on staff to perform oral hygiene. At the time of the MDS assessment, R98 required supervision or touching assistance for eating. However, R98 was reevaluated by SLP upon return from the hospital on 3/10/26 which indicated they now required 1:1 feeding assistance.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview and record review, the facility failed to adhere to professional standards of practice to assess and monitor the continued need for a PICC (Peripheral Inserted Central Catheter) for antibiotic administration for one (R4) of one reviewed for Intravenous (IV) therapy. Findings include:Clinical record review revealed R4 was admitted to facility on 3/12/26 for osteomyelitis (infection in the bone) of the left foot requiring amputation of the toes and required administration of intravenous (IV) antibiotics via PICC (Peripheral Inserted Central Catheter) line, had Acute Kidney Injury (AKI) due to kidney failure and required hemodialysis. R4 was alert, orientated, and capable of making their needs known.On 4/6/26 around 10:30 AM, during initial introductions, R4 voiced concern of the PICC line observed in their right upper arm. R4 said the PICC was placed for antibiotics, not used in a while. When asked if the line was flushed (to maintain patency), R4 said the last time someone tried, it would not flush. R4 said it is uncomfortable and starting to annoy them. The dressing was observed dated 3/18, the adhesive edging was rolled not entirely adhered to the skin and the transparent window of the dressing was observed with a large amount of dark brown dried blood at the insertion site. The inside lumen of the catheter was observed with dried blood. R4 said there are times the clear part of the dressing would bubble and they would have to press the air out of the dressing.Record review documented on 3/14/26 to flush the PICC with 10 millimeter (ml) normal saline for IV maintenance until 3/23/26. Monitor the site every shift until 3/23/26.Record review documented on 3/16/2026- Change transparent dressing to PICC every day shift every Monday for IV maintenance until 3/23/26.Record Review of the Medication Administration Record (MAR) documented the last date of antibiotic infusion was on 3/17/26.On 4/8/26 at 8:30 AM, the Director of Nursing (DON) and Unit Manager Licensed Practical Nurse (LPN) N was interviewed and questioned if the above orders were dated to monitor until 3/23/26 and the dressing was observed dated 3/18/26, why was the PICC line still in R4's arm, the DON had no comment.Document review revealed on 4/6/26 at 12:00 PM shortly after R4 was interviewed, LPN N had placed an order to discontinue the PICC related to antibiotic completion. When asked what triggered them to obtain this order, LPN N said they noticed R4 had a PICC line and then realized they no longer received antibiotics. When asked if this was their first encounter with R4, LPN N stated no, they are a resident on their hall and they do daily rounds Monday-Friday. When asked why it was not addressed by Nursing until 4/6/26 and maintenance of the PICC was ceased on 3/23/26, LPN N said they never saw the PICC until 4/6/26 and when questioned if Nursing had seen the PICC line why was the need for it not addressed, both the DON and LPN N had no response, and acknowledged the PICC should have been assessed to be discontinued sooner than 4/6/26.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview and record review, the facility failed to ensure that two Certified Nursing Assistants (CNA NN and SS) out of five CNAs reviewed for competency evaluations received new hire evaluations, continuous yearly evaluations and 1:1 training regarding falls and transfers. This deficient practice had the potential to affect all residents at the facility, including R5. Findings include: CNA NN On 4/6/26 at approximately 12:19 PM, R5 was observed lying in bed. Their left arm was in a sling. R5 reported that on 3/4/26, a CNA (herein after CNA NN) turned them on their side and placed a bedpan on the bed. CNA NN then left the room leaving them on their side, and they rolled off the bed. They were sent to the Hospital and diagnosed with a fracture to their left shoulder. A review of the facility Incident/Accident (IA) Report involving R5 revealed the following: .Alleged Incident.Date: 3/4/26.Resident (R5).Brief Description: Nurse was alerted to resident's room. (R5) was observed lying on the floor. She complained of left shoulder pain. Was transported to the hospital for evaluation. Upon return facility was notified of a left shoulder fracture.Summary of Resident Interview.Guest (R5).Said that she needed to have a bowel movement. CNA came to the room, rolled her on her side.left out of the room. She felt a lump in the mattress.could not move her leg and she fell out of bed.Staff Member Interview (RN MM).heard yelling. Went to (R5's) room and observed her lying on the floor. Called for assistance and 911.Staff Member Interview (CNA NN).resident's call light was on.resident said she needed to have a bowel movement.the resident asked her to roll her on her side.left out of the room to give privacy.was out of the room for about 15 minutes when heard a page for assistance. On 4/7/26 at approximately 1:13 PM, an attempt to interview CNA NN via phone was made. A voice mail could not be left. The facility was asked to have CNA NN contact the Surveyor. No contact was received by the end of the survey. On 4/8/26 at approximately 8:29 AM, a phone interview was conducted with RN MM. RN MM was asked about the incident involving R5 on 3/4/26. RN MM reported that they were working that evening and while in the hall they could hear someone yelling loudly. They were able to locate them on the floor closest to the wall near the window. They immediately assessed the resident, determined that they were in significant pain and called 911 and EMS (emergency medical services) to have the resident transferred to the hospital. RN MM was asked if they were aware of how R5 fell. They reported that CNA NN turned R5 on their side and placed a bedpan/commode on the bed, they then left the room. RN MM noted that CNA NN should never have left the resident alone as they were bedbound, obese and had nothing to hold on to while on their side. RN MM reported that following in the incident they provided 1:1 training with CNA NN. The Administrator was asked to provide CNA NNs personnel file. The file indicated the resident was hired as a CNA on or about 1/20/26. There were no documents in the file that indicated CNA NN had received either initial training upon hire or 1:1 training regarding R5's fall. CNA SSOn 4/8/26 at approximately 4:00 PM, the Administrator was asked to provide documentation regarding yearly competency reviews for CNA SS. CNA SS had been hired as a CNA on 1/7/2025. The last competency evaluation was done upon hire. No yearly training or evaluation was provided.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to implement and follow policies and procedures for Enhanced Barrier Precautions (EBP) for one (R4) of one reviewed for EBP. Findings include:Clinical record review revealed R4 was admitted to facility on 3/12/26 for osteomyelitis (infection in the bone) of the left foot requiring amputation of the toes and required administration of intravenous (IV) antibiotics via PICC (Peripheral Inserted Central Catheter) line, had Acute Kidney Injury (AKI) due to kidney failure and required hemodialysis. R4 was alert, orientated, and capable of making their needs known.On 4/8/26 at 11:30 AM, A pressure ulcer dressing observation with Licensed Practical Nurse (LPN) Q was conducted for R4. Prior to entering R4's room, it was observed there was no EBP signage or Personal Protective Equipment (PPE). LPN Q was observed donning only gloves to cleanse and provide treatment to an unstageable (full-thickness skin and tissue loss in which the extent of tissue damage with the ulcer cannot be confirmed) coccyx pressure ulcer that was observed with an open spit horizontal wound with yellow colored slough.On 4/8/26 at 11:45 AM, LPN Q who started at the facility a few months ago was asked if they were educated about Enhanced Barrier Precautions when hired and replied Yes When asked if R4 should be on EBP LPN Q said I don't think so they don't have a foley (urinary catheter) and not on antibiotics I can figure it out though.On 4/8/26 at 12:50 PM Infection Control Registered Nurse (RN) R was interviewed and asked if a resident has a pressure wound that requires dressing changes, do they qualify for EBP? RN R said they did. When asked how the facility is alerted on which resident should be on EBP, they discussed in daily meetings. When asked why R4 was not on EBP, RN R did not know and acknowledged they should be.Review of the facility policy titled Enhanced Barrier Precautions (EBP) dated 3/5/2025 documented: .It is the intent of this facility to use Enhanced Barrier Precautions (EBP) in addition to standard precautions for preventing the transmission of.targeted multidrug-resistant organisms.generally include.pressure ulcers.Post signage for precautions on the door or wall outside of the residents room indicating the type of precautions and required PPE.