| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235538 | A. Building<br>B. Wing | 03/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mission Point Health Campus of Jackson | 703 Robinson Road<br>Jackson, MI 49203 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and 2 (R16, R55) of 16 sampled residents, the facility failed to provide palatable food products affecting 46 residents who consume food, resulting in the increased likelihood for residents decreased food acceptance and nutritional decline.Findings include:R55:<br><br>Review of the medical record reflected R55 admitted to the facility on [DATE], with diagnoses that included lumbar region discitis (inflammation/swelling between spinal vertebrae) and sepsis due to Group B streptococcus (a type of bacteria). The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/26/26, reflected R55 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).<br><br>On 03/01/2026 at 11:21 AM, R55 was observed seated in a standard chair, in their room. R55 reported the facility's food was terrible. R55 reported they nibbled at the food but had not found any of it they liked yet. R55 reported having shakes (Boost), which they drank sometimes. R55 reported being unsure if there was an alternate food menu and did not think they were being offered anything else if they did not eat what was served.<br><br>On 03/02/2026 at 9:57 AM, R55 was observed seated on the edge of the bed. A breakfast tray, including scrambled eggs, ham and a biscuit was observed on the overbed table. R55 stated the ham was good. When asked why it looked like they had not eaten much of the meal, R55 stated it was probably cold by that time, as the residents were told they could sleep in that morning.<br><br>Review of R55's food acceptance record, on 3/4/26 at 2:43 PM, reflected they had consumed zero percent (%) of their meal two times, 25% of their meal three times, 50% of their meal 13 times, 75% of their meal six times, 100% of their meal one time and had refused a meal three times. Documentation did not reflect that R55 was offered an alternate meal option when their meal consumption was decreased.<br><br>In an interview on 03/04/2026 at 2:28 PM, Registered Dietitian (RD) H reported it was up to the Certified Nurse Aide (CNA) on whether or not an alternate meal was offered for refusal or poor consumption of a meal. RD H reported the task documentation for amount eaten (food acceptance) did not include a question pertaining to an alternate being offered.<br><br>In an interview on 03/04/2026 at 2:49 PM, Director of Nursing (DON) B reported if a resident did not like what was on their tray, staff always offered an alternate. DON B reported they always had sandwiches available, as well as snacks on the unit. DON B reported they personally had taken R55's tray to them several times, and they wanted an alternative.<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #16 (R16)<br><br>Review of the medial medical record revealed R16 was admitted to the facility 01/02/2026 with diagnoses that included type 2 diabetes, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), end stage renal disease, pancytopenia (lower than normal red and white blood cells and platelets in blood), nonalcoholic steatohepatitis (fatty liver), cirrhosis of liver (scared and permanently damaged liver), heart failure, gastric ulcer (open sores of stomach lining), esophageal varices (enlarged veins in the esophagus, the tube that connects to throat and the stomach), fractured left femur (upper bone of the leg), fracture left patella (knee cap), fracture left tibia (bone in lower leg), peripheral vascular disease (PVD), gastro-esophageal reflux, thrombocytopenia (low platelet count), and depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/17/2026, revealed R16 had a Brief Interview of Mental Status (BIMS) of 15 (intact cognition) out of 15.<br><br>During observation and interview on 03/01/2026 at 08:47 a.m. R16 was observed sitting up in bed attempting to eat breakfast. Two waffles were observed on R16's plate and did not appear to be toasted. R16 explained that the waffles were not cooked and were cold. R16 explained that the waffles were also wet. R16 explained that it was her opinion that the facility placed frozen waffles on her plate and let them thaw.<br><br>On 03/01/2026 at 12:50 p.m. a test tray as delivered to the conference room where the survey team was located. Observation of the lunch test tray revealed pork loin, green beans, mashed potatoes with gravy, blue berry cobbler, and cranberry juice. Consumption of the test tray by surveyor noted the pork loin to be lukewarm, the green beans were very soft and appeared to be overcooked and mushy, and the gravy appeared to be gelatinous (having a consistency of jelly).<br><br>On 03/01/2026 at 11:55 A.M., an interview was conducted with Dietary Manager P regarding the resident meal tray delivery schedule. Dietary Manager P stated that meals are delivered to the 100 Hall and 300 Hall to Town Square, and then 200 Hall, and finally The Main Dining Room is served to residents as they arrive.<br><br>On 03/01/2026 at 12:00 P.M., the 100 Hall and 300 Hall resident lunch meal food trays (22) were observed leaving the food production kitchen, within an insulated food transport cart, and arrived at Town Square at 12:02 PM.<br><br>On 03/01/2026 at 12:07 P.M., The last lunch meal food tray was observed served to R312. R312 was also observed to decline their lunch meal food tray.<br><br>On 03/01/2026 at 12:23 P.M., the 200 Hall resident lunch meal food trays (22) were observed leaving the food production kitchen, within an insulated food transport cart, and arrived at the 200 Hall at 12:24 PM.<br><br>On 03/02/2026 at 12:08 P.M., The 100 Hall and 300 Hall resident lunch meal food trays (18) were observed leaving the food production kitchen, within an insulated food transport cart, and arrived at Town Square at 12:09 PM.<br><br>On 03/02/2026 at 12:22 P.M., The 200 Hall resident lunch meal food trays (22) were observed leaving<br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | the food production kitchen, within an insulated food transport cart, and arrived at the 200 Hall at 12:23 PM.<br><br>On 03/02/2026 at 12:28 P.M., food product temperatures were monitored utilizing a rapid read digital thermometer. The following food product temperatures were recorded for R16's lunch meal food tray:<br><br>Oven Roasted Tilapia - 137.5Rice Pilaf – On Resident Dislike ListWinter Vegetable Blend - 128.4*Iced Apple Cake – On Resident Dislike ListBeverage (Lemonade) - 52.1<br><br>(*) The 2022 FDA Model Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 degrees C (135 degrees F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 degrees C (41 degrees F) or less. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: (1) effectively clean food service equipment, (2) effectively date mark all potentially hazardous ready-to-eat food products, and (3) label and date all food products affecting 46 residents who consume food, resulting in the increased likelihood for cross-contamination, bacterial harborage, and resident foodborne illness.Findings include:On 03/01/2026 at 8:50 A.M., an initial tour of the food service was conducted with Dietary [NAME] M, Dietary Aide N, Dietary Aide O, and Dietary Manager P. The following items were noted:On 03/01/2026 at 9:15 A.M., the mechanical dish machine stainless steel ventilation hood was observed soiled and corroded from excessive moisture exposure.On 03/01/2026 at 9:33 A.M., the ice machine blue plastic scoop caddy was observed soiled with accumulated and encrusted mineral (calcium and lime) deposits.The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.On 03/01/2026 at 9:34 A.M., 2 of 2 fabric upholstered chairs, located adjacent to the ice machine, were observed heavily stained with accumulated and encrusted soils. On 03/01/2026 at 9:35 A.M., one black vinyl covered swivel chair, located adjacent to the 2-door reach-in cooler, was observed with 2 of 2 arm rest pads etched and scored. The 2022 FDA Model Food Code section 6-501.114 states: The PREMISES shall be free of: (A) Items that are unnecessary to the operation or maintenance of the establishment such as EQUIPMENT that is nonfunctional or no longer used; and (B) Litter.On 03/01/2026 at 9:39 A.M., one gallon (one-third full) of 2% Milk was observed within the True 2-door reach-in cooler, without an open or discard date. The manufacturer's use-by-date was also observed to read 3-10-26. One-half gallon container (one-fourth full) of chocolate milk was observed within the True 2-door reach-in cooler, without an effective open or discard date. The manufacturer's use-by-date was also observed to read 3-8-26.The 2022 FDA Model Food Code section 3-501.17 states: (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.On 03/01/2026 at 9:59 A.M., one hotel pan of Chicken Fillets (marinating) was observed in the True 2-door reach-in cooler covered with clear plastic wrap, without an effective date mark. One hotel pan of Chicken pieces was also observed in the True 2-door reach-in cooler covered with plastic wrap, without an effective date mark. One hotel pan of Beef Broth was further observed in the True 2-door reach-in cooler covered with plastic wrap, without an effective date mark.On 03/01/2026 at 10:05 A.M., an interview was conducted with Dietary Manager P regarding dating and labeling of food products. Dietary Manager P stated that all of the food products should have been dated and labeled by staff and that they will have to retrain staff on proper dating and labeling.The 2022 FDA Model Food Code section 3-602.11 states: (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD; (3) An accurate declaration of the net<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | quantity of contents; (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients, displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin.On 03/01/2026 at 10:12 A.M., The South Bend convection oven interior and exterior surfaces were observed soiled with accumulated and encrusted food residue. Dietary Manager P stated that the unit has been out of service for approximately five months. The Pitco fryer interior cabinet and door surface were also observed soiled with accumulated and encrusted grease deposits. The South Bend char broiler was observed soiled with accumulated and encrusted food residue.On 03/01/2026 at 10:21 A.M., The [NAME] steamer support table was observed with accumulated and encrusted food residue. Dietary Manager P stated that the steamer and support table are cleaned weekly.On 03/01/2026 at 10:26 A.M., The commercial toaster interior and exterior surfaces were observed with accumulated and encrusted food residue.The 2022 FDA Model Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.On 03/01/2026 at 10:44 A.M., the side [NAME] tabletop surface was observed missing the laminate edge piece, within the Private Dining Room. The damaged edge piece measured approximately five-feet-long. The hand sink cabinet door hinge was also observed loose-to-mount.The 2022 FDA Model Food Code section 6-501.11 states: PHYSICAL FACILITIES shall be maintained in good repair.On 03/01/2026 at 10:54 A.M., the Main Dining Room hand sink faucet assembly and adjacent laminate surface area was observed soiled with accumulated and encrusted mineral (calcium and lime) deposits.The 2022 FDA Model Food Code section 4-602.13 states: NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.On 03/01/2026 at 11:00 A.M., the Town Square Kitchenette microwave oven was observed with accumulated and encrusted food residue.The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.On 03/01/2026 at 11:05 A.M., the Town Square Kitchenette hand sink faucet assembly was observed loose-to-mount.The 2022 FDA Model Food Code section 5-205.15 states: A plumbing system shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.On 03/01/2026 at 11:11 A.M., the 200 Hall Kitchenette microwave oven interior was observed with accumulated and encrusted food residue.The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.On 03/04/2026 at 10:30 A.M., record review of the Policy/Procedure entitled: Food Storage dated 01/2024 revealed under Policy: Food storage areas shall be maintained in a clean, safe, and sanitary manner. This includes maintaining temperatures of coolers and freezers at the appropriate temperature to promote food safety. Record review of the Policy/Procedure entitled: Food Storage dated 01/2024 further revealed under Policy Explanation and Compliance Guidelines: (3) Refrigerated food outside of original package shall be labeled, dated, and (continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | monitored so that it is used by the use-by-date, frozen, or discarded, whichever is applicable. (a) Fresh produce will have a receive date and be monitored for quality, discarding bruised or spoiled products. (b) Milk received and unopened will be stored according to manufacturer use-by/expiration date. Once opened it will be labeled with open and use-by-date, but not to exceed expiration date. (5) Ready-to-eat food can be stored by expiration date, until opened, then labeled with open and use-by-date, if not discarded.On 03/04/2026 at 10:45 A.M., record review of the Policy/Procedure entitled: Cleaning Equipment and Utensils dated 01/2024 revealed under Policy: Equipment and utensils will be properly cleaned and sanitized to prevent contamination. Record review of the Policy/Procedure entitled: Cleaning Equipment and Utensils dated 01/2024 further revealed under Purpose: Safe food handling and minimize the risk of cross-contamination.On 03/04/2026 at 11:00 A.M., record review of the Policy/Procedure entitled: Leftover Foods dated 01/05/2021 revealed under Policy: Leftovers will be handled according to 2013 Food Code regulation. Record review of the Policy/Procedure entitled: Leftover Foods dated 01/05/2021 further revealed under Purpose: To maintain safe food handling and minimize the risk of foodborne illness. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant affecting 46 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage.Findings include:Resident R14 (#14)<br><br>Review of the medical record revealed R14 was admitted to the facility 08/14/2025 with diagnoses that included colon cancer, protein calorie malnutrition, thrombocytopenia (low platelet count), autistic disorder, paranoid schizophrenia, bipolar disorder, dementia, adjustment disorder, hypothyroidism (low thyroid hormone), ileostomy (an opening in the abdomen that connects the last part of the small bowel to the outside of the body), and cognitive communication deficit. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/14/2025, revealed R14 had a Brief Interview of Mental Status (BIMS) of 12 (moderate cognitive impairment) out of 15.<br><br>Prior to entering R14's room on 03/01/2026 at 09:05 a.m. Licensed Practical Nurse (LPN) V explained that it was necessary to place foot coverings, located outside the room, over your shoes before entering R14's room. LPN V explained that R14 had a history of removing his ileostomy bag (a device that collects stool from the ileostomy) and throwing feces on the floor.<br><br>Upon entering R14's room on 03/01/2026 at 09:08 a.m. it was observed that the floor had two dark spots on the carpet, in front of R14's couch. The dark spots appeared to be feces. R14's room smelled of feces. R14 was observed lying in bed and did not respond to verbal stimuli.<br><br>On 03/02/2026 at 01:05 PM A common area environmental tour was conducted with Environmental Services Director (ESD) K and Housekeeping and Laundry Supervisor (HLS) L. The following items were noted:<br><br>On 03/02/2026 at 1:10 P.M., the following observations were made within Resident room [ROOM NUMBER]: The carpeted flooring surface, the gray vinyl landing strip (adjacent to the resident bed), the bedside tabletop surface and metal support frame were observed soiled with accumulated and encrusted food residue. A strong pervasive urine odor was present. The Portable Terminal Air Conditioning (PTAC) Unit filters were heavily soiled with accumulated and encrusted dust/dirt deposits. The carpeted surface was soiled with accumulated and encrusted feces and bodily fluids residue.<br><br>On 03/02/2026 at 1:16 P.M., the following observations were made within Resident room [ROOM NUMBER]: The carpeted flooring surface was observed soiled with accumulated and encrusted food residue. The Portable Terminal Air Conditioning (PTAC) Unit exterior cabinetry was observed soiled with accumulated and encrusted food residue, and the interior PTAC discharge grill surface was observed containing whole food particles and debris. The PTAC Unit filters were heavily soiled with accumulated and encrusted dust/dirt deposits. The restroom hand sink faucet assembly was observed soiled with accumulated and encrusted dirt and mineral (calcium and lime) deposits.<br><br>On 03/02/2026 at 1:27 P.M., the following observations were made within Resident room [ROOM NUMBER]: The carpeted flooring surface was observed severely soiled with accumulated and encrusted bodily fluids/solids. The resident room was observed with an intense pervasive malodorous (continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | condition. The PTAC Unit filters were observed heavily soiled with accumulated and encrusted dust/dirt deposits. The carpeted surface, located directly outside of the entrance door, was further observed worn, stained, frayed, and missing.<br><br>On 03/02/2026 at 1:48 P.M., the following observations were made within Resident room [ROOM NUMBER]: The carpeted flooring surface was observed soiled with accumulated and encrusted food residue. The room was also observed in complete disarray, with numerous personal items resting upon furniture surfaces. The PTAC Unit filters were observed heavily soiled with accumulated and encrusted dust/dirt deposits. The restroom hand sink basin was observed to be heavily soiled. The drywall surface, located directly behind the resident chair, measuring approximately 16-inches-wide by 16-inches-long, was observed etched and scored. The carpeted surface, located directly outside of the entrance door, was observed etched, worn, frayed, and missing.<br><br>The carpeting surface adjacent to the 100 Hall Nursing Station was observed worn, frayed, and with the seams worn and separated, exposing the concrete subsurface.<br><br>The carpeting surface and seams, adjacent to the 200 Hall Nursing Station were observed worn and frayed. The damaged carpeting surface measured approximately 12-inches- wide by 26-feet-long. The worn internal carpeting primary backing was also observed, adjacent to the carpeting seams.<br><br>The 200 Hall Spa (Lift Sling Storage Room) was observed in disarray. Lift slings were observed stored in a pile, resting directly on the flooring surface. (ESD) K indicated he would have staff clean and organize the Lift Sling Storage Room as soon as possible.<br><br>The facility carpeting surface was observed etched, worn, and frayed, adjacent to the 300 Hall Nursing Station. The carpeted surface seams were also observed worn, frayed, and separated.<br><br>On 03/02/2026 at 4:05 P.M., an interview was conducted with Executive Director A regarding the flooring surface, within Resident room [ROOM NUMBER]. Executive Director A stated that the plan is to clean the room routinely, and that the. resident is not educatable and currently has a colostomy located in a bad space (skin fold). Executive Director A further stated that the ultimate plan is to remove the carpeting and replace the flooring surface with laminate material.<br><br>On 03/04/26 at 01:00 P.M., record review of the Policy/Procedure entitled: Environmental Services Inspection dated 1/11/2021 revealed under Policy: It is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis.<br><br>On 03/04/2026 at 01:15 P.M., record review of the Policy/Procedure entitled: Safe and Homelike Environment dated 1/11/2021 revealed under Policy: In accordance with resident's rights, the facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Record review of the Policy/Procedure entitled: Safe and Homelike Environment dated 1/11/2021 further revealed under Policy Explanation and Compliance Guidelines: (3) Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.<br><br>On 03/04/2026 at 01:30 P.M., record review of the Direct Supply TELS Work Orders for the last 120 days revealed no specific entries related to the aforementioned maintenance concerns. |

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| | 235538 | A. Building<br>B. Wing | 03/04/2026 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain a wound care program, that included weekly wound care assessments and treatments in five residents (R2, R5, R16, R29, R46) of five residents investigated for pressure ulcers.Findings IncludeResident #2 (R2)<br><br>Review of the medical record reflected that R2 was admitted to the facility on [DATE]. Diagnoses of cerebral infarction due to unspecific occlusion or stenosis of the left middle cerebral artery, hemiplegia and hemiparesis on affecting right dominate side, aphasia, dysphagia, and protein- calorie malnutrition.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/24/2026 revealed R2 had a Brief Interview of Mental Status (BIMS) of 07 (severe cognitive impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R2 needed maximum assistance with showering and personal care. R2 was dependent on toileting, lower body dressing, and perineal hygiene.<br><br>During an interview with DON B on 03/04/26 at 7:15 AM, DON B stated she had just completed the wound care assessment on R2 at 0630 AM this morning, stated she contacted the NP and received new orders and discontinued the old orders due to the status of the pressure ulcer. Had this writer not brought this wound to the attention of the DON B, this wound assessment would not have been completed today under normal circumstances.<br><br>Record review of the timeline of R2's pressure ulcer that was received by the DON B just prior to completion of the survey noted .area to right heal was noted on 01/14/2026 and treatment was initiated. Area measured 2cm x 2 cm with no depth noted at this time of discovery. The provider was notified of the open area. Treatment continued to area with current measurements of 1.1cm x 0.6cm with no depth.<br><br>New Orders 03/04/26- Cleanse left heel with NS. Apply Xeroform to wound bed and cover with foam dressing. Change every day and as needed.<br><br>02/26/26 IDT note. Interdisciplinary Team (IDT) met to review due to open area on heel. Treatment in place, continue to monitor. Continue to encourage good nutrition intake to promote wound healing.<br><br>No weekly wound assessment completed the week of 02/23/2026.<br><br>02/24/26- NP. Noted a small right heel ulcer, continue current topical treatment to right heel ulcer, discussed with nursing.<br><br>Weekly skin sweep dated 02/24/26 reported rt heel, coccyx, right and left lower leg, no measurements recorded.<br><br>02/17/26- NP. continue current treatment due to right heel ulcer, slow healing. Plan- continue current treatment due to right heel, slow healing, guarded prognosis secondary to immobility, multiple comorbidities, nutrition status. Noted small right heel ulcer with pink base with some brown drainage.<br><br>No weekly wound assessment completed the week of 02/16/2026.<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | No Weekly Skin Sweep for the week of 02/16/2026<br><br>Weekly skin sweep dated 02/10/26 reported right heel, right lower leg, left lower leg, coccyx no measurements recorded.<br><br>No weekly wound assessment completed the week of 02/09/2026.<br><br>02/03/26 NP. Re-evaluate right heel pressure ulcer and response to current treatment. Plan- continue current topical treatment to right heel ulcer, pressure relieving devices, frequent repositioning. Small right heel ulcer with pink base, scant amount of drainage.<br><br>No weekly wound assessment completed the week of 02/02/2026.<br><br>No Weekly Skin Sweep completed the week of 02/02/2026.<br><br>01/27/26- NP. No mention of a pressure ulcer.<br><br>No weekly wound assessment completed the week of 01/26/2026.<br><br>01/26/26- Nutrition note-nursing noted an open area on her right heel.<br><br>Weekly skin sweep dated 01/25/26 reported right heel, coccyx, left lower leg, rt lower leg with no measurements recorded.<br><br>MDS dated [DATE] reported 1 pressure ulcer at stage 2.<br><br>01/21/26- Refused to have dressing changed.<br><br>01/20/26- NP. new order-Calcium alginate, R2 seen today to evaluate right heel ulcer. Small right heel ulcer, pinkish wound bed with some surrounding maceration.<br><br>01/20/26- discontinued 03/04/26<br><br>Right heel ulcer. Cleanse with NS, apply calcium alginate and cover with Allevyn.<br><br>Change daily. Apply skin prep to surrounding skin and to left heel.<br><br>No Weekly Skin Sweep the week of 01/19/2026<br><br>No weekly wound assessment completed in the week of 01/19/2026.<br><br>01/14/26- nursing note- R was complaining of pain in her right foot, upon assessment, a pressure ulcer was noted. NP and DON notified. Change in condition done.<br><br>Weekly Skin Sweep on 01/14/26 reported rash/excoriation on the sacrum, right buttock, left buttock.<br><br>01/14/26- discontinued 01/20/26<br><br>Apply skin prep to bilateral heels. Cover right heel pressure ulcer with comfort foam dressing. Change<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | daily and prn.<br><br>No weekly wound assessment completed the week of 01/12/2026.<br><br>No Weekly Skin Sweep the week of 01/12/2026.<br><br>01/08/26- Alert note- impaired skin integrity was documented, treatment in placed.<br><br>Weekly skin sweep dated 01/07/26 reports rash/excoriation<br><br>No weekly wound assessment completed the week of 01/05/2026.<br><br>No Weekly Skin Sweep the week of 01/05/2026.<br><br>12/30/25- No other new skin issues, rash resolved. Dr. MD<br><br>No weekly wound assessment completed the week of 12/29/2025.<br><br>No Weekly Skin Sweep the week of 12/29/2025.<br><br>12/23/25- No other skin issues besides rash on left arm. NP<br><br>No weekly wound assessment completed the week of 12/22/2025.<br><br>No Weekly Skin Sweep the week of 12/22/2025.<br><br>12/15/2025-<br><br>No weekly wound assessment completed the week of 12/15/2025.<br><br>No Weekly Skin Sweep the week of 12/15/2025.<br><br>12/08/2025-<br><br>No weekly wound assessment completed the week of 12/08/2025.<br><br>No Weekly Skin Sweep the week of 12/08/2025.<br><br>12/01/2025-<br><br>No weekly wound assessment completed the week of 12/01/2025.<br><br>No Weekly Skin Sweep the week of 12/01/2025.<br><br>11/20/2025- Impaired skin integrity was documented, known skin condition, assessment completed.<br><br>10/21/25- Weekly Skin Sweep completed.<br><br>09/02/25-Nursing progress note, notes approx. 1 cm circular, appearance of abrasion/open area on<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the coccyx. Daughter and provider notified.<br><br>09/02/25 NP noted approx 1 cm circular, appearance of abrasion/open area on the coccyx, pink surrounding tissue blanchable, no active bleeding, until after the area softly patted with normal saline than noticed small amount of bright red blood to site. No applied ointment and no further bleeding noted. Covered with 4x4.<br><br>Resident #5 (R5)<br><br>Review of the medical record reflected that R5 was admitted to the facility on [DATE]. Diagnoses of non-pressure chronic ulcer of the other part of right foot with necrosis of bone, respiratory failure, chronic obstructive pulmonary disease, muscle weakness, abnormalities of gait and mobility, chronic pain syndrome, and dementia.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/16/2026 revealed R5 had a Brief Interview of Mental Status (BIMS) of 13 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R5 needed maximum assistance with showering and personal care. R5 was dependent on toileting, lower body dressing, and perineal hygiene.<br><br>During an observation and interview on 03/02/2026 at 10:22 AM Observation of Licensed Practical Nurse (LPN) R perform wound care on R5's right foot 4th. LPN R performed hand hygiene, applied gloves, laid a blue pad under the right foot, old/soiled dressings removed, performed hand hygiene, applied gloves, wounds cleaned with normal saline and gauze dressing. LPN R then removed dressing from right heel, performed hand hygiene applied new gloves, held foot up in the air with left hand approx 1' off the floor, trying to measure heel wound from around the inside with his right hand, and had to learn over to get to the measurements of 2.5 x .5 in depth. LPN R was not able to view the pressure ulcer straight on to get accurate measurements. LPN R removed his gloves, hand hygiene completed, swabbed iodine with sterile Q-tips to both pressure ulcers, right foot on the 4th toe and right foot heel. Band aide applied to 4th toes on right foot, and foam dressing to right heel. LPN R removed gloves, completed hand hygiene.<br><br>Record review revealed provider order for right foot great toe, not the 4th toe. Apply iodine to black scab to right big toe everyday shift for skin integrity. Written on 1/10/2026 06:00. Order for right heel-Cleanse right heel with NS, apply iodine to open area and cover with foam dressing. Everyday shift for skin integrity. 1/10/2026 06:00. Cover red/pink area to buttocks with 4x4 foam dressing -change daily and as needed. Every day shift and change as needed. Written on 12/25/25.<br><br>During an observation and interview on 03/02/2026 at 1:47 PM, LPN R was performing wound care on R5's coccyx, he stated they use this dressing to provide a barrier for his skin. Observed 2 areas noted to be pink, stage 1 on the inner edges of his buttock on the right side and the left side just above the anus, also observed a pink area was noted on the bottom side of scrotum. Observed blanchable areas on both hips, with the right hip covered with foam dressing for protection. Observed LPN R hand sanitized and put gloves on, cleaned the buttock and scrotum with normal saline, put gloves after hand hygiene, applied barrier cream to scrotum, buttock and coccyx, removed his gloves and performed hand hygiene, applied new gloves, covered the coccyx with a foam dressing. Removed gloves and performed hand hygiene.<br><br>During an interview on 03/02/2026 at 3:55 PM, DON B was asked what the provider's orders were for<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R5's pressure ulcer and altered skin integrity. DON B stated there was an order for right foot great toe, the right foot heel, and the right hip. Writer asked DON B what the order was for the right foot, 4th toe. DON B stated they didn't have one because that isn't the toe being treated. Writer informed DON B that the right foot great toe was healed and did not observed treatment to that toe. Writer also informed DON B the order for the great toe is still active and not discontinued when the wound healed. There was not an order for the treatment on the right foot, 4th toe that was performed.<br><br>DON B stated she was unaware of an issue with the right foot, 4th toe. DON B also stated she was going down to assess the 4th toe and the appropriate treatment. Writer asked DON B how this was missed and asked if Weekly Wound Assessments and Weekly Skin Sweeps were capturing those skin concerns. DON B stated they were not completing these assessments routinely. Writer asked DON B who their provider was that was overseeing the facilities pressure ulcer and skin alterations. DON B stated that they did not have one at this time. DON B stated she had called NP or MD and told them what was going on with the resident's skin and asked for orders for wound care treatment.<br><br>During this same interview writer asked DON B who was responsible for the wound care program overall. DON B stated she was overseeing the wound care program, but they did not have a wound care provider. DON B stated said wound care provider parted ways the end of November 2025. DON B added the floor nurses were supposed to be measuring the wounds and putting in the assessments, Weekly Skin Sweeps were not getting done completely, Wound Care Assessments were not done weekly, the ones that were done did not include all 3 wounds, just the right heel wound.<br><br>03/02/26- Weekly Skin Sweep- not completed.<br><br>03/02/26- Weekly Wound Assessment- not completed.<br><br>02/23/26- Weekly Wound Assessment- not completed.<br><br>02/24/26 Weekly Skin Sweep- blanchable red area and open area. Did not list the site or a description.<br><br>02/16/26- Weekly Wound Assessment- not completed.<br><br>02/17/26- Weekly Skin Sweep- discoloration, blanchable red area, open area. Right heel- open area, under treatment. Sacrum- blanchable redness to area under treatment.<br><br>02/09/26- Weekly Wound Assessment- not completed.<br><br>02/10/26- Weekly Skin Sweep- discoloration, blanchable red area, open area. Right heel- open area under treatment. Sacrum- blanchable redness to area under treatment. Other- bruising purple in color noted on bilateral forearms.<br><br>02/02/26- Weekly Wound Assessment- Right heel pressure ulcer- 3.0cm x 2cm x 0.1cm. Treatment- cleanse with normal saline, pat dry, apply Betadine to wound bed, cover with foam dressing.<br><br>02/02/26- Weekly Skin Sweep- not completed.<br><br>01/26/26- Weekly Skin Sweep- not completed.<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 01/26/26- Weekly Wound Assessment- not completed.<br><br>01/24/26- Weekly Skin Sweep- Blanchable red area and open area. Right heel- open area, treatment ordered. Sacrum- blanchable redness.<br><br>01/24/26-Weekly Wound Assessment- right heel pressure ulcer- 2.6cm x 2.3cm x 0.1cm. Treatment- cleanse with normal saline, pat dry, apply Betadine to wound bed, cover with foam dressing.<br><br>01/19/26- Weekly Skin Sweep- not completed.<br><br>01/16/26- Weekly Skin Sweep- Blanchable red area and open area, surgical wound site. Right heel- open area to right heel. Sacrum- blanchable redness to sacrum and buttocks. Other- Right great toe lesion. Other- Suprapubic catheter.<br><br>01/16/26- Weekly Wound Assessment- right heel pressure ulcer- 3cm x 2.7cm x 0.2cm. Treatment- cleanse with normal saline, part dry, apply Betadine to wound bed, cover with foam dressing.<br><br>01/05/26- Weekly Skin Sweep- not completed.<br><br>01/05/26- Weekly Wound Assessment- not completed.<br><br>12/29/25- Weekly Skin Sweep. not completed.<br><br>12/29/25- Weekly Wound Assessment. Not completed.<br><br>12/22/25- Weekly Skin Sweep. not completed.<br><br>12/22/25- Weekly Wound Assessment. Not completed.<br><br>12/17/25- Weekly Wound Assessment- right heel pressure ulcer- 0.4cm x 0.3cm x 3cm. Stage 4. Treatment- right heel cleanse with normal saline, apply small amount of calcium alginate to wound bed, cover with foam bordered dressing.<br><br>12/16/25- Weekly Skin Sweep- Open area- left heel- wound care orders in place.<br><br>12/10/25- Weekly Wound Assessment- Right heel pressure ulcer- 0.3cm x 0.3cm x 0. Stage 4. Treatment- right heel cleansed with normal saline, apply small amount of calcium alginate to wound bed, cover with foam bordered dressing.<br><br>12/09/25- Weekly Skin Sweep- marked none-skin intact. Right heel, stage 2 pressure ulcer. Wound care orders in place.<br><br>12/03/25- Weekly Wound Assessment- Right heel pressure ulcer- 0.5cm x 0.4cm x 0. Stage 4. Treatment- right heel cleansed with normal saline, apply small amount of calcium alginate to wound bed, cover with foam bordered dressing.<br><br>12/03/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of Right heel cleansed with normal saline. Apply small amount to calcium alginate to wound bed. Cover with bordered gauze. Type: pressure<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 12/02/25- Weekly Skin Sweep- open area- right heel- wound care orders in place.<br><br>11/30/25- Weekly Skin Sweep- open area- right heel- wound care orders in place.<br><br>11/26/25- Provider assessed wound. Pressure ulcer of right heel, stage 4: Off load pressure with frequent repositioning. Others relevant intervention: Right heel cleansed with normal saline. Apply small amounts to calcium alginate to wound bed. Cover with bordered gauze. Type: pressure<br><br>11/26/25- Weekly Wound Assessment- right heel pressure ulcer 0.8cm x 1.0cm x 0.1cm. stage 4. Treatment- left heel cleansed with normal saline. Apply small amount of calcium alginate to wound bed, cover with bordered gauze.<br><br>11/23/25- Weekly Skin Sweep- Blanchable red area. Coccyx intact, right heel- small open area.<br><br>11/23/25- Weekly Skin Sweep- Coccyx was intact, right heel had small open area.<br><br>11/19/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of right heel, stage 4: Off load pressure with frequent repositioning. Others relevant intervention: Cleanse right heel wound with normal saline and pat dry, apply calcium alginate cover with boarder gauze. Pressure ulcer unavoidable: No Measurements:<br><br>11/19/25- Weekly Wound Assessment- right heal pressure ulcer 0.8cm x 0.5cm x 0.2cm. Treatment- left heel cleansed with normal saline, apply small amount of calcium alginate to wound bed, cover with bordered gauze.<br><br>11/17/25- Weekly Skin Sweep. Not completed.<br><br>11/14/25- Weekly Skin Sweep- right ankle outer- open are to the right heel, under treatment. Sacrum- blanchable redness.<br><br>11/13/25- Weekly Wound Assessment- right heel pressure ulcer- 1.5cm x 1.5cm x 0.10cm, stage 4. Treatment- left heel pressure ulcer cleansed with normal saline, area painted with Betadine, foam bordered dressing applied to cover site.<br><br>11/12/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of right heel, stage 4: Off load pressure with frequent repositioning. Others relevant intervention: Cleanse right heel wound with normal saline and pat dry, paint with betadine and apply foam border dressing to site. Pressure ulcer unavoidable: No Measurements:<br><br>11/07/25- Weekly Skin Sweep- right heel- open area to right heel, treatment ordered. Sacrum was blanchable redness to sacrum.<br><br>11/05/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of right heel, stage 4: Off load pressure with frequent repositioning. Others relevant intervention: Clean with NS pat dry paint with Iodine, apply foam dressing. Pressure ulcer unavoidable: No Measurements:<br><br>11/05/25- Weekly Wound Assessment- right heel pressure ulcer- 1.0cm x 0.5cm x 0. Stage 4. Treatment- left heel cleansed with normal saline, are painted with Betadine, foam bordered dressing applied to cover site.<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 11/04/25-Weekly Skin Sweep- right heel pressure ulcer had an open sore, treatment ordered and completed as ordered. Sacrum was blanchable redness to sacrum.<br><br>10/29/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of right heel, stage 4: Off load pressure with frequent repositioning. Others relevant intervention: Keep Rt heel scab over area clean and place foam border on daily and as needed for safety and comfort. Pressure ulcer unavoidable: No Measurements:<br><br>10/29/25- Weekly Wound Assessment- right heel pressure ulcer, 0.5cm x 0.5cm x 0, stage 4. No treatment documented.<br><br>10/22/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of right heel, stage 4: Off load pressure with frequent repositioning. Others relevant intervention: Clean buttocks with NS, apply barrier cream, cover with foam patch. Pressure ulcer unavoidable: No Measurements:<br><br>10/22/25- Weekly Skin Sweep. Not completed.<br><br>10/22/25- Weekly Wound Assessment. Not completed.<br><br>10/16/25- Weekly Wound Assessment. Right heel pressure ulcer- 0.5cm x 0.5cm x 0, stage 4. Treatment- cleanse with normal saline and continue collagen fiber.<br><br>10/15/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of right heel, stage 4: Off load pressure with frequent repositioning. Others relevant intervention: Clean with NS pat dry apply calcium alginate cover with foam gauze. Pressure ulcer unavoidable: No Measurements:<br><br>10/15/25- Weekly Skin Sweep. Not completed.<br><br>10/15/25. Weekly Wound Assessment. Not completed.<br><br>10/09/25. Weekly Wound Assessment- Right heel pressure ulcer- 0.5cm x 0.5cm x 0. Stage 4. Treatment- cleanse with normal saline and continue collagen fiber.<br><br>10/06/25- Weekly Skin Sweep. Not completed.<br><br>10/02/25- Weekly Wound Assessment- Right heel pressure ulcer 1.0cm x 1.0cm x 0. Stage 4. Treatment- cleanse with normal saline and continue collagen fiber.<br><br>09/29/25- Weekly Skin Sweep- Not completed.<br><br>09/25/25- Weekly Skin Sweep- Coccyx red and right heel had an open area on right heel, treatment orders ongoing.<br><br>09/22/25- Weekly Wound Assessment. Not completed.<br><br>09/18/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of right heel, stage 4: Stage 4 pressure ulcer right heel. Others relevant intervention: Treatment is collagen packing dry dressing. Right heel stage 4 pressure ulcerMeasures 2.0 cm x 2.0 cm x 0.2 cm<br>(continued on next page) |

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| | 235538 | A. Building<br>B. Wing | 03/04/2026 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 09/18/25- Weekly Wound Assessment- right heel pressure ulcer 2.0cm x 2.0cm x 0. Stage 4. Treatment- cleanse with normal saline and continue collagen fiber.<br><br>09/15/25- Weekly Skin Sweeps. Not completed.<br><br>09/12/25-Weekly Wound Assessment- Right heel pressure ulcer-2.0cm x 2.5cm x 0.3cm. Stage 4. Treatment- cleanse with normal saline and continue collagen fiber.<br><br>09/11/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of right heel, stage 4: Stage 4 pressure ulcer right heel. Others relevant intervention: Treatment is collagen packing dry dressing. Right heel stage 4 pressure ulcerMeasures 2.0 cm x 2.0 cm x 0.2 cm<br><br>09/09/25- Weekly Skin Sweep- blanchable red area but no site listed.<br><br>09/08/25-Weekly Wound Assessment- Right heel pressure ulcer- 0.5cm x 0.5cm x 0. Stage 4. Treatment- Cleanse with normal saline and continue collagen fiber.<br><br>09/04/25- Provider assessed wound- rt heel, stage 4. Pressure ulcer of right heel, stage 4: Stage 4 pressure ulcer right heel. Others relevant intervention: Treatment is collagen packing dry dressing. Right heel stage 4 pressure ulcer. Measures 2.0 cm x 2.5 cm x 0.2 cm.<br><br>09/01/25- Weekly Wound Assessment- Right heel- 0.5cm x 0.5cm x 0.1cm. Stage 4. Treatment- cleanse with normal saline and continue collagen fiber.<br><br>09/01/25 Weekly Skin Sweep. Not completed.<br><br>Noted, R5 did not receive regular weekly skin sweeps, weekly wound assessment, oversight from a wound care provider, measurements of the pressure ulcers were not consistent, treatment of the pressure ulcers did not fit the status of the pressure ulcers, right heel pressure ulcer, but treatment was written on the wound assessments for left heel, not right.<br><br>Wound care orders for buttocks (cover red/pink area with 4x4 foam dressing), however this order was used on sacrum, coccyx and buttock, not identifying a new pressure ulcer area.<br><br>Resident #29 (R29)<br><br>Review of the medical record reflected that R29 was admitted to the facility on [DATE]. Diagnoses of acute kidney failure, osteomyelitis of left ankle and foot, paraplegia, cognitive communication deficit and severe protein-calorie malnutrition.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/27/2026 revealed R29 had a Brief Interview of Mental Status (BIMS) of 13 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R29 was dependent on toileting, lower body dressing, showering and personal care.<br><br>Record review revealed R29's last Minimum Data Set (MDS) assessment dated [DATE] was marked having no pressure ulcers.<br><br>During an interview on 03/04/2026 at12:37 PM, MDS Coordinator F stated that assessment did not<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | include the measurements and staging of any pressure ulcers so she cannot put in the information if it's not documented. MDS Coordinator F stated DON B told her she had the information but had not put the information in before the 7-day window. MDS Coordinator F stated if it wasn't added in during the 7 days, she couldn't add it.<br><br>Record review revealed R29 did not have Weekly Skin Sweeps, Weekly Wound Assessment. Writer requested a copy of all Weekly skin Sweeps and Weekly Wound Assessments and did not receive any prior to exiting the survey.<br><br>02/24/26- Provider progress note. No mention of the pressure ulcers.<br><br>02/17/26- Provider progress note. No mention of the pressure ulcers.<br><br>02/13/26- Provider Progress notes. No mention of the pressure ulcers.<br><br>02/05/26- Provider progress notes. No mention of the pressure ulcers.<br><br>02/04/26- Provider progress notes. Gives a history of present illnesses. No mention of current pressure ulcers.<br><br>Resident #16 (R16)<br><br>Review of the medial medical record revealed R16 was admitted to the facility 01/02/2026 with diagnoses that included type 2 diabetes, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), end stage renal disease, pancytopenia (lower than normal red and white blood cells and platelets in blood), nonalcoholic steatohepatitis (fatty liver), cirrhosis of liver (scared and permanently damaged liver), heart failure, gastric ulcer (open sores of stomach lining), esophageal varices (enlarged veins in the esophagus, the tube that connects to throat and the stomach), fractured left femur (upper bone of the leg), fracture left patella (knee cap), fracture left tibia (bone in lower leg), peripheral vascular disease (PVD), gastro-esophageal reflux, thrombocytopenia (low platelet count), and depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/17/2026, revealed R16 had a Brief Interview of Mental Status (BIMS) of 15 (intact cognition) out of 15.<br><br>During observation and interview on 03/04/2026 at 09:15 a.m. R16 as observed lying down in bed. R16 explained that she had an open area on her bottom. R16 could not explain if the open area was present upon admission or if it was acquired at the facility. R16 explained that the open area had been improving.<br><br>Review of R16's medical record revealed a document entitled Admission/readmission Assessment-V2.2, completion date of 02/11/2026, revealed: site: 31) right buttock, Type: open area, length: (blank), and width: (blank). Review of document entitled Weekly Skin Sweep, effective date of 02/15/2026, revealed: Site: 23) Coccyx, Description: open area measured 2cm(centimeters) length and 0.5cm with. and Site: 32) Left buttock, Description: open area 2cm length by 2cm width. Review of document entitled Weekly Skin Sweep, effective date of 03/01/2026, revealed: Site: 53) Sacrum, Description: open area-treatment applied. R16's medical record did not contain any documentation entitled Wound Assessment V2.1 (document completed weekly to include measurements and staging of wounds).<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R16's medical record did not contain any documentation of the wound by the attending physician.<br><br>Review of R16's medical record did not demonstrate that the wound had been included in her Plan of Care.<br><br>Review of R16's medical record revealed a physician order, initiated 02/15/2026 and to start 02/16/2025), which stated, clean coccyx and right buttocks with normal saline. Then apply hydrophilic sound ointment to wound bed and cover with foam dressing change daily and PRN (as needed) in the afternoon for wound care.<br><br>On 03/04/2026 at 09:17 a.m. R16 was observed lying down in bed. Licensed Practical Nurse (LPN) S was observed explaining dressing procedure to R16. R16 was rolled to her left side with the assistance of Certified Nursing Aide (CNA) T. R16's brief was removed and no dressing was observed on R16's bottom. LPN S proceeded to cleanses R16's open wound, which was located to the left of her coccyx, with normal saline. After cleansing of wound Director of Nursing (DON) B performed measurements of the wound. R16's open wound to the left of her coccyx was observed to be 1.4cm (centimeters) in length, 1.0 cm in width, and 0.1cm in depth. The wound bed was observed to be red with granulation tissue present. DON B verbalized that R16's wound was a stage 2 pressure ulcer. LPN S was then observed to apply hydrophilic wound ointment to wound bed and covered the wound with a foam dressing.<br><br>In an interview on 03/04/2026 at 10:04 a.m. Director of Nursing (DON) B explained that residents are assessed upon admission, and a complete skin assessment was completed within 24 hours. DON B explained that if a wound was present measurements would be recorded and a description of the wound be recorded. DON B explained that if the assessing nurse was a Registered Nurse, then the wound would be staged appropriately. DON B explained that the attending physician would be contacted and a treatment order would be obtained. DON B explained that if a current resident was found to have any skin wounds that she was to be notified and she would ensure that the assessment was completed, the treatment was initiated, and the physician would view the wound and document appropriately. DON B explained that it was facility policy that skin sweeps are to be completed weekly. DON B explained if a resident had a skin wound that a Wound Assessment V2.1 document would be completed weekly. DON B explained that residents with skin issues and/or open wounds would be included in their plan of care.<br><br>DON B confirmed that R16 did not have a treatment order for her wound until 02/16/2026. DON B confirmed that R16 did not have a Weekly Skin Sweep document completed weekly. DON B confirmed that R16 did not have a Wound Assessment document completed when R16's wound was identified or completed weekly. DON B confirmed that R16's medical record had not revealed that the attending physician had recorded any documentation regarding R16's wound, progression of the wound, or treatment of the wound. DON B confirmed that R16's Care Plan did not include her stage 2 pressure ulcer or interventions to prevent or assist in the healing of the wound.<br><br>Resident # 46 (R46)<br><br>Review of the medical record reflected R46 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included acute respiratory failure with hypoxia, diabetes and acquired absence of the left leg, below the knee. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/12/26, reflected R46 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was at risk of developing pressure (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | ulcers/injuries.<br><br>On 03/03/2026 at 3:28 PM, R46 was observed lying in bed, on their back, on a standard mattress. A wheelchair, at the right bedside, was noted to have a seating cushion in place. R46 stated before their initial admission to the facility, they had a rash on their bottom. R46 acknowledged a dressing was in place, on their bottom, which was changed the night prior. To R46's knowledge, the skin was not open or draining.<br><br>An Admission/readmission Assessment, dated 2/6/26, reflected non-blanchable (skin color does not fade when pressed on) redness to R46's sacrum.<br><br>A Nurse Practitioner Progress Note for 2/7/26 reflected, .Wound coccyx dressing order placed .<br><br>A Physician's Order, with a revision date of 2/15/26 and a start date of 2/17/26, reflected to cleanse the coccyx wound with barrier or bath wipes, cover with silicone border foam dressing and change every three days and as needed.<br><br>The February 2026 Treatment Administration Record (TAR) reflected treatment to the sacrum/coccyx did not begin until 2/17/26.<br><br>R46's medical record reflected Weekly Skin Sweeps, dated 1/13/26, 1/28/26 and 2/13/26, which were marked for, Scar and Surgical wound site.<br><br>In an interview on 03/04/2026 at 10:04 AM, Director of Nursing (DON) B reported at the time of readmission from the hospital, on 2/6/26, R46 had non-blanchable redness on the sacrum, which indicated a stage one pressure ulcer was present. DON B reported she would have expected the wound to be staged, measured and fo |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure there was Physician oversight and orders for care provided in three residents (R2, R5 and R16) out of five residents.Finding IncludeResident #2 (R2)<br><br>Review of the medical record reflected that R2 was admitted to the facility on [DATE]. Diagnoses of cerebral infarction due to unspecific occlusion or stenosis of the left middle cerebral artery, hemiplegia and hemiparesis on affecting right dominate side, aphasia, dysphagia, and protein- calorie malnutrition.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/24/2026 revealed R2 had a Brief Interview of Mental Status (BIMS) of 07 (severe cognitive impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R2 needed maximum assistance with showering and personal care. R2 was dependent on toileting, lower body dressing, and perineal hygiene.<br><br>During an interview with DON B on 03/04/26 at 7:15 AM, DON B stated she had just completed the wound care assessment on R2 at 0630 AM this morning, stated she contacted the NP and received new orders and discontinued the old orders due to the status of the pressure ulcer. Had this writer not brought this wound to the attention of the DON B, this wound assessment would not have been completed today under normal circumstances.<br><br>Record review of the timeline of R2's pressure ulcer that was received by the DON B just prior to completion of the survey noted .area to right heal was noted on 01/14/2026 and treatment was initiated. Area measured 2cm x 2 cm with no depth noted at this time of discovery. The provider was notified of the open area. Treatment continued to area with current measurements of 1.1cm x 0.6cm with no depth.<br><br>New Orders 03/04/26- Cleanse left heel with NS. Apply Xeroform to wound bed and cover with foam dressing. Change every day and as needed.<br><br>02/26/26 IDT note. Interdisciplinary Team (IDT) met to review due to open area on heel. Treatment in place, continue to monitor. Continue to encourage good nutrition intake to promote wound healing.<br><br>No weekly wound assessment completed the week of 02/23/2026.<br><br>02/24/26- NP. Noted a small right heel ulcer, continue current topical treatment to right heel ulcer, discussed with nursing.<br><br>Weekly skin sweep dated 02/24/26 reported rt heel, coccyx, right and left lower leg, no measurements recorded.<br><br>02/17/26- NP. continue current treatment due to right heel ulcer, slow healing. Plan- continue current treatment due to right heel, slow healing, guarded prognosis secondary to immobility, multiple comorbidities, nutrition status. Noted small right heel ulcer with pink base with some brown drainage.<br><br>No weekly wound assessment completed the week of 02/16/2026.<br>(continued on next page) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | No Weekly Skin Sweep for the week of 02/16/2026<br><br>Weekly skin sweep dated 02/10/26 reported right heel, right lower leg, left lower leg, coccyx no measurements recorded.<br><br>No weekly wound assessment completed the week of 02/09/2026.<br><br>02/03/26 NP. Re-evaluate right heel pressure ulcer and response to current treatment. Plan- continue current topical treatment to right heel ulcer, pressure relieving devices, frequent repositioning. Small right heel ulcer with pink base, scant amount of drainage.<br><br>No weekly wound assessment completed the week of 02/02/2026.<br><br>No Weekly Skin Sweep completed the week of 02/02/2026.<br><br>01/27/26- NP. No mention of a pressure ulcer.<br><br>No weekly wound assessment completed the week of 01/26/2026.<br><br>01/26/26- Nutrition note-nursing noted an open area on her right heel.<br><br>Weekly skin sweep dated 01/25/26 reported right heel, coccyx, left lower leg, rt lower leg with no measurements recorded.<br><br>MDS dated [DATE] reported 1 pressure ulcer at stage 2.<br><br>01/21/26- Refused to have dressing changed.<br><br>01/20/26- NP. new order-Calcium alginate, R2 seen today to evaluate right heel ulcer. Small right heel ulcer, pinkish wound bed with some surrounding maceration.<br><br>01/20/26- discontinued 03/04/26<br><br>Right heel ulcer. Cleanse with NS, apply calcium alginate and cover with Allevyn.<br><br>Change daily. Apply skin prep to surrounding skin and to left heel.<br><br>No Weekly Skin Sweep the week of 01/19/2026<br><br>No weekly wound assessment completed in the week of 01/19/2026.<br><br>01/14/26- nursing note- R was complaining of pain in her right foot, upon assessment, a pressure ulcer was noted. NP and DON notified. Change in condition done.<br><br>Weekly Skin Sweep on 01/14/26 reported rash/excoriation on the sacrum, right buttock, left buttock.<br><br>01/14/26- discontinued 01/20/26<br><br>Apply skin prep to bilateral heels. Cover right heel pressure ulcer with comfort foam dressing. Change<br>(continued on next page) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | daily and prn.<br><br>No weekly wound assessment completed the week of 01/12/2026.<br><br>No Weekly Skin Sweep the week of 01/12/2026.<br><br>01/08/26- Alert note- impaired skin integrity was documented, treatment in placed.<br><br>Weekly skin sweep dated 01/07/26 reports rash/excoriation<br><br>No weekly wound assessment completed the week of 01/05/2026.<br><br>No Weekly Skin Sweep the week of 01/05/2026.<br><br>12/30/25- No other new skin issues, rash resolved. Dr. MD<br><br>No weekly wound assessment completed the week of 12/29/2025.<br><br>No Weekly Skin Sweep the week of 12/29/2025.<br><br>12/23/25- No other skin issues besides rash on left arm. NP<br><br>No weekly wound assessment completed the week of 12/22/2025.<br><br>No Weekly Skin Sweep the week of 12/22/2025.<br><br>12/15/2025-<br><br>No weekly wound assessment completed the week of 12/15/2025.<br><br>No Weekly Skin Sweep the week of 12/15/2025.<br><br>12/08/2025-<br><br>No weekly wound assessment completed the week of 12/08/2025.<br><br>No Weekly Skin Sweep the week of 12/08/2025.<br><br>12/01/2025-<br><br>No weekly wound assessment completed the week of 12/01/2025.<br><br>No Weekly Skin Sweep the week of 12/01/2025.<br><br>11/20/2025- Impaired skin integrity was documented, known skin condition, assessment completed.<br><br>10/21/25- Weekly Skin Sweep completed.<br><br>09/02/25-Nursing progress note, notes approx. 1 cm circular, appearance of abrasion/open area on<br>(continued on next page) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the coccyx. Daughter and provider notified.<br><br>09/02/25 NP noted approx 1 cm circular, appearance of abrasion/open area on the coccyx, pink surrounding tissue blanchable, no active bleeding, until after the area softly patted with normal saline than noticed small amount of bright red blood to site. No applied ointment and no further bleeding noted. Covered with 4x4.<br><br>Resident #5 (R5)<br><br>Review of the medical record reflected that R5 was admitted to the facility on [DATE]. Diagnoses of non-pressure chronic ulcer of the other part of right foot with necrosis of bone, respiratory failure, chronic obstructive pulmonary disease, muscle weakness, abnormalities of gait and mobility, chronic pain syndrome, and dementia.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/16/2026 revealed R5 had a Brief Interview of Mental Status (BIMS) of 13 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R5 needed maximum assistance with showering and personal care. R5 was dependent on toileting, lower body dressing, and perineal hygiene.<br><br>During an observation and interview on 03/02/2026 at 10:22 AM Observation of Licensed Practical Nurse (LPN) R perform wound care on R5's right foot 4th. LPN R performed hand hygiene, applied gloves, laid a blue pad under the right foot, old/soiled dressings removed, performed hand hygiene, applied gloves, wounds cleaned with normal saline and gauze dressing. LPN R then removed dressing from right heel, performed hand hygiene applied new gloves, held foot up in the air with left hand approx 1' off the floor, trying to measure heel wound from around the inside with his right hand, and had to learn over to get to the measurements of 2.5 x .5 in depth. LPN R was not able to view the pressure ulcer straight on to get accurate measurements. LPN R removed his gloves, hand hygiene completed, swabbed iodine with sterile Q-tips to both pressure ulcers, right foot on the 4th toe and right foot heel. Band aide applied to 4th toes on right foot, and foam dressing to right heel. LPN R removed gloves, completed hand hygiene.<br><br>Record review revealed provider order for right foot great toe, not the 4th toe. Apply iodine to black scab to right big toe everyday shift for skin integrity. Written on 1/10/2026 06:00. Order for right heel-Cleanse right heel with NS, apply iodine to open area and cover with foam dressing. Everyday shift for skin integrity. 1/10/2026 06:00. Cover red/pink area to buttocks with 4x4 foam dressing -change daily and as needed. Every day shift and change as needed. Written on 12/25/25.<br><br>During an observation and interview on 03/02/2026 at 1:47 PM, LPN R was performing wound care on R5's coccyx, he stated they use this dressing to provide a barrier for his skin. Observed 2 areas noted to be pink, stage 1 on the inner edges of his buttock on the right side and the left side just above the anus, also observed a pink area was noted on the bottom side of scrotum. Observed blanchable areas on both hips, with the right hip covered with foam dressing for protection. Observed LPN R hand sanitized and put gloves on, cleaned the buttock and scrotum with normal saline, put gloves after hand hygiene, applied barrier cream to scrotum, buttock and coccyx, removed his gloves and performed hand hygiene, applied new gloves, covered the coccyx with a foam dressing. Removed gloves and performed hand hygiene.<br><br>During an interview on 03/02/2026 at 3:55 PM, DON B was asked what the provider's orders were for<br>(continued on next page) |

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|---|---|---|---|
| | 235538 | A. Building<br>B. Wing | 03/04/2026 |

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| Mission Point Health Campus of Jackson | 703 Robinson Road<br>Jackson, MI 49203 |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R5's pressure ulcer and altered skin integrity. DON B stated there was an order for right foot great toe, the right foot heel, and the right hip. Writer asked DON B what the order was for the right foot, 4th toe. DON B stated they didn't have one because that isn't the toe being treated. Writer informed DON B that the right foot great toe was healed and did not observed treatment to that toe. Writer also informed DON B the order for the great toe is still active and not discontinued when the wound healed. There was not an order for the treatment on the right foot, 4th toe that was performed.<br><br>DON B stated she was unaware of an issue with the right foot, 4th toe. DON B also stated she was going down to assess the 4th toe and the appropriate treatment. Writer asked DON B how this was missed and asked if Weekly Wound Assessments and Weekly Skin Sweeps were capturing those skin concerns. DON B stated they were not completing these assessments routinely. Writer asked DON B who their provider was that was overseeing the facilities pressure ulcer and skin alterations. DON B stated that they did not have one at this time. DON B stated she had called NP or MD and told them what was going on with the resident's skin and asked for orders for wound care treatment.<br><br>During this same interview writer asked DON B who was responsible for the wound care program overall. DON B stated she was overseeing the wound care program, but they did not have a wound care provider. DON B stated said wound care provider parted ways the end of November 2025. DON B added the floor nurses were supposed to be measuring the wounds and putting in the assessments, Weekly Skin Sweeps were not getting done completely, Wound Care Assessments were not done weekly, the ones that were done did not include all 3 wounds, just the right heel wound.<br><br>Resident #16 (R16)<br><br>Review of the medial medical record revealed R16 was admitted to the facility 01/02/2026 with diagnoses that included type 2 diabetes, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), end stage renal disease, pancytopenia (lower than normal red and white blood cells and platelets in blood), nonalcoholic steatohepatitis (fatty liver), cirrhosis of liver (scared and permanently damaged liver), heart failure, gastric ulcer (open sores of stomach lining), esophageal varices (enlarged veins in the esophagus, the tube that connects to throat and the stomach), fractured left femur (upper bone of the leg), fracture left patella (knee cap), fracture left tibia (bone in lower leg), peripheral vascular disease (PVD), gastro-esophageal reflux, thrombocytopenia (low platelet count), and depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/17/2026, revealed R16 had a Brief Interview of Mental Status (BIMS) of 15 (intact cognition) out of 15.<br><br>During observation and interview on 03/04/2026 at 09:15 a.m. R16 as observed lying down in bed. R16 explained that she had an open area on her bottom. R16 could not explain if the open area was present upon admission or if it was acquired at the facility. R16 explained that the open area had been improving.<br><br>Review of R16's medical record revealed a document entitled Admission/readmission Assessment-V2.2, completion date of 02/11/2026, revealed: site: 31) right buttock, Type: open area, length: (blank), and width: (blank). Review of document entitled Weekly Skin Sweep, effective date of 02/15/2026, revealed: Site: 23) Coccyx, Description: open area measured 2cm(centimeters) length and 0.5cm with. and Site: 32) Left buttock, Description: open area 2cm length by 2cm width. Review of document entitled Weekly Skin Sweep, effective date of 03/01/2026, revealed: Site: 53) Sacrum, Description: open area-treatment applied. R16's medical record did not contain any documentation entitled Wound Assessment V2.1 (document completed weekly to include measurements and staging<br>(continued on next page) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of wounds).<br><br>R16's medical record did not contain any documentation of the wound by the attending physician.<br><br>Review of R16's medical record did not demonstrate that the wound had been included in her Plan of Care.<br><br>Review of R16's medical record revealed a physician order, initiated 02/15/2026 and to start 02/16/2025), which stated, clean coccyx and right buttocks with normal saline. Then apply hydrophilic sound ointment to wound bed and cover with foam dressing change daily and PRN (as needed) in the afternoon for wound care.<br><br>On 03/04/2026 at 09:17 a.m. R16 was observed lying down in bed. Licensed Practical Nurse (LPN) S was observed explaining dressing procedure to R16. R16 was rolled to her left side with the assistance of Certified Nursing Aide (CNA) T. R16's brief was removed and no dressing was observed on R16's bottom. LPN S proceeded to cleanses R16's open wound, which was located to the left of her coccyx, with normal saline. After cleansing of wound Director of Nursing (DON) B performed measurements of the wound. R16's open wound to the left of her coccyx was observed to be 1.4cm (centimeters) in length, 1.0 cm in width, and 0.1cm in depth. The wound bed was observed to be red with granulation tissue present. DON B verbalized that R16's wound was a stage 2 pressure ulcer. LPN S was then observed to apply hydrophilic wound ointment to wound bed and covered the wound with a foam dressing.<br><br>In an interview on 03/04/2026 at 10:04 a.m. Director of Nursing (DON) B explained that residents are assessed upon admission, and a complete skin assessment was completed within 24 hours. DON B explained that if a wound was present measurements would be recorded and a description of the wound be recorded. DON B explained that if the assessing nurse was a Registered Nurse then the wound would be staged appropriately. DON B explained that the attending physician would be contacted and a treatment order would be obtained. DON B explained that if a current resident was found to have any skin wounds that she was to be notified and she would ensure that the assessment was completed, the treatment was initiated, and the physician would view the wound and document appropriately. DON B explained that it was facility policy that skin sweeps are to be completed weekly. DON B explained if a resident had a skin wound that a Wound Assessment V2.1 document would be completed weekly. DON B explained that residents with skin issues and/or open wounds would be included in their plan of care.<br><br>DON B confirmed that R16 did not have a treatment order for her wound until 02/16/2026. DON B confirmed that R16 did not have a Weekly Skin Sweep document completed weekly. DON B confirmed that R16 did not have a Wound Assessment document completed when R16's wound was identified or completed weekly. DON B confirmed that R16's medical record had not revealed that the attending physician had recorded any documentation regarding R16's wound, progression of the wound, or treatment of the wound. DON B confirmed that R16's Care Plan did not include her stage 2 pressure ulcer or interventions to prevent or assist in the healing of the wound. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to maintain Dignity in one (R31) of 16 residents when yelling out for help.Findings IncludeResident #31 (R31)Review of the medical record reflected that R31 was admitted to the facility on [DATE]. Diagnoses of displaced Tri malleolar fracture of right lower leg, history of a stroke, polyneuropathy, obesity and rheumatoid arthritis.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2026 revealed R31 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively impact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R31 needed substantial assistance with showering and personal care. R31 was dependent on toileting, lower body dressing, and perineal hygiene.During an observation and interview on 03/01/2026 at 8:51 AM, R31 stated she was supposed to be up in her wheelchair and ready for physical therapy, but the CNA assigned to her did not get her up in time for physical therapy. R31 stated nobody answered her call light for two hours, added that she yelling for help hoping someone would come in and help her. R31 stated during this time, physical therapy (PT) X came into her room to see if she was ready for her session, but she was still in bed. R31 stated her CNA finally came in and got her up in her wheelchair for physical therapy and moved her wheelchair over by the television, across the room. R31 stated the CNA did not give her the call light so she had no way of calling for help other than yelling out. R31 stated this was on Friday 02/27/26.During an interview on 03/02/26 at 3:55pm, Director of Nursing (DON) B stated she had not been notified of this concern. DON B stated she would go down to the R31's room and talk to her about that dignity issue.During an interview on 03/03/2026 at 11:28 AM, DON B stated she had discussed the concern with R31. DON B stated R31 told her she had a rough day on Friday, as she was set away from her call light and could not reach it. DON B asked R31 who her CNA was that day and R31 told her it was CNA X.Observation and interview on 03/03/2026 at 11:42 AM, CNA X was working with R31 today. Call light was in reach, R31stated today was a much better day, CNA X was more attentive to her needs and made sure she had everything she needed before leaving the room. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide timely Notice of Medicare Non-Coverage for one (R37) of four reviewed.Findings include: Review of the medical record reflected R37 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included cerebral infarction (stroke). The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/2/26, reflected R37 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 03/02/2026 at 1:36 PM, R37 was observed lying in bed and did not recall receiving notification for the end of Medicare Part A services. R37's Notice of Medicare Non-Coverage document reflected their last covered day of Medicare Part A benefits was 11/18/25. The document was signed with R37's name on 11/17/25. According to the document, .How to ask for an immediate appeal .Ask for the appeal as soon as possible. You must ask for a timely appeal no later than noon of the day before the above date . In an interview on 03/02/2026 at 2:14 PM, Social Worker D reported residents were given 48 hours' notice for Notice of Medicare Non-Coverage. SW D reported they had until noon on the day before the last covered day to file an appeal. SW D acknowledged that R37 was not provided with a 48-hour notice for their Notice of Medicare Non-Coverage. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on observation, interview, and record review the facility failed to provide and document evidence of prompt resolution to a grievance for missing personal items of one (resident #16) out of one resident reviewed.Findings Included:Resident #16 (R16)Review of the medial medical record revealed R16 was admitted to the facility 01/02/2026 with diagnoses that included type 2 diabetes, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), end stage renal disease, pancytopenia (lower than normal red and white blood cells and platelets in blood), nonalcoholic steatohepatitis (fatty liver), cirrhosis of liver (scared and permanently damaged liver), heart failure, gastric ulcer (open sores of stomach lining), esophageal varices (enlarged veins in the esophagus, the tube that connects to throat and the stomach), fractured left femur (upper bone of the leg), fracture left patella (knee cap), fracture left tibia (bone in lower leg), peripheral vascular disease (PVD), gastro-esophageal reflux, thrombocytopenia (low platelet count), and depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/17/2026, revealed R16 had a Brief Interview of Mental Status (BIMS) of 15 (intact cognition) out of 15. During observation and interview on 03/01/2026 at 10:35 a.m. R16 was observed lying in bed. R16 explained that she had lost a shirt at the facility. R16 explained that she had informed Certified Nursing Aide (CNA) Q. R16 explained that staff were unable to find the shirt. R16 explained that staff were going to bring her a Concern Information form but had yet provided it to her. R16 explained that the she had reported the missing shirt the previous week. Review of the facility Grievance Log had not demonstrated that R16 had filed a Concern Information form. In an interview on 03/02/2026 at 11:09 a.m. Certified Nursing Aide (CNA) Q explained that R16 had reported to her that she was missing one pair of pants and two shirts. CNA Q explained that she had located and returned the pants and one shirt to R16. CNA Q explained that she had not completed a Concern Information form for R16's shirt that could not be found. CNA Q explained that the event had occurred the previous week. CNA Q could not explain why she had not completed a Concern Information form or provided one to R16. CNA Q explained that she would complete a Concern Information and provide it to Nursing Home Administrator (NHA) A. In an interview on 03/02/2026 at 11:15 a.m. Nursing Home Administrator (NHA) A confirmed that there were no Concern Information forms for R16. NHA A explained that it was his expectation and the facility policy that a Concern Information form was to be completed for missing clothing. Review of the facility policy Resident and Family Grievances, date of implementation 07/03/2007 and last revised 06/2024, revealed 10. Procedure: b. The staff member receiving the grievance will record the nature and specifics of the grievance on a designated resident assistance form or assist the resident or family member to complete the form. C. Forward the grievance form to the Grievance Officer as soon as possible. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement comprehensive care plan for three residents (#16,#31,#40) of 16 residents reviewed for care plan development and implementation. Resident #31 (R31)<br><br>Review of the medical record reflected that R31 was admitted to the facility on [DATE]. Diagnoses of displaced Tri malleolar fracture of right lower leg, history of a stroke, polyneuropathy, obesity and rheumatoid arthritis.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2026 revealed R31 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively impact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R31 needed substantial assistance with showering and personal care. R31 was dependent on toileting, lower body dressing, and perineal hygiene.<br><br>During an observation and interview on 03/01/2026 at 8:56 AM, R31 stated she doesn't get down to the activities because it took so much to get her up in her wheelchair and taken down there. Writer asked if the activity department brings her things to do in her room and she stated no. No observation of any activity's information, calendar or items visible in her room.<br><br>During an interview on 03/03/26 at 7:49 AM, Activity Director (AD) AA stated they had four activities daily and the therapy department offers an exercise event on Fridays and everyone is invited. AD AA stated their hours are from 8:15am to 4:45pm. They cover the whole building, assisted living and long-term care. These hours were set up so they could help with breakfast trays in the morning, lunch trays and the dinner tray at the end of their day. First activity is at 9:00am, a word search, or provide one on one room visits, word puzzles, puzzles, crafts, magazines, books, activity is under task. Writer asked AD AA where they document which activities residents attend or the amount of time they spend on the one on ones. AD AA stated they cannot document the amount of time they spend with residents. AD AA added that they stop in the resident's room to check in on them throughout the week. AD AA stated they talk to other staff and if residents complain of being boarded but refuse everything, they note that. AD AA stated works closely with therapy department. Writer asked to look at the activity calendar for February and March.<br><br>March calendar started out with a TV program first thing in the morning, no documentation on efforts with collaboration after tuning the TV on. Room visits do not reflect what the intent is or what they plan on doing during that visit. Resident Council meetings are listed as an activity. Popcorn cart delivering popcorn to residents was listed. The calendar did reflect an interactive activity with puzzles, church services, kitchen activities, bunco, card games, and crafts on certain days. Saturday activity was a game at 2:00pm and nothing else and Sunday activities were church and a game at 2:00pm. The calendar of events had a lot of times with no activities to do.<br><br>During an observation and interview on 03/03/2026 at 9:39 AM, no observation of any activity materials visible in R31's room. R31 stated nobody had been in to talk to her about doing things that she would enjoy during her time at the facility.<br><br>Record review revealed the care plan had a focus on having/offering therapeutic activities that<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | support her rehab goals. R31's goal was to have her participate in leisure activities of interest almost daily. Interventions/task indicated that the following items were important to her including TV programs and news, cell phone use, social media, conversations and visits with family and friends. Please provide room supplies upon her request and encourage her to join groups of interest. The care plan interventions had not been implemented as established on 02/04/2026.<br><br>Resident #16 (R16)<br><br>Review of the medial medical record revealed R16 was admitted to the facility 01/02/2026 with diagnoses that included type 2 diabetes, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), end stage renal disease, pancytopenia (lower than normal red and white blood cells and platelets in blood), nonalcoholic steatohepatitis (fatty liver), cirrhosis of liver (scared and permanently damaged liver), heart failure, gastric ulcer (open sores of stomach lining), esophageal varices (enlarged veins in the esophagus, the tube that connects to throat and the stomach), fractured left femur (upper bone of the leg), fracture left patella (knee cap), fracture left tibia (bone in lower leg), peripheral vascular disease (PVD), gastro-esophageal reflux, thrombocytopenia (low platelet count), and depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/17/2026, revealed R16 had a Brief Interview of Mental Status (BIMS) of 15 (intact cognition) out of 15.<br><br>During observation and interview on 03/04/2026 at 09:15 a.m. R16 as observed lying down in bed. R16 explained that she had an open area on her bottom. R16 could not explain if the open area was present upon admission or if it was acquired at the facility. R16 explained that the open area had been improving.<br><br>Review of R16's medical record revealed a document entitled Admission/readmission Assessment-V2.2, completion date of 02/11/2026, revealed: site: 31) right buttock, Type: open area, length: (blank), and width: (blank). Review of document entitled Weekly Skin Sweep, effective date of 02/15/2026, revealed: Site: 23) Coccyx, Description: open area measured 2cm(centimeters) length and 0.5cm with. and Site: 32) Left buttock, Description: open area 2cm length by 2cm width. Review of document entitled Weekly Skin Sweep, effective date of 03/01/2026, revealed: Site: 53) Sacrum, Description: open area-treatment applied. R16's medical record did not contain any documentation entitled Wound Assessment V2.1 (document completed weekly to include measurements and staging of wounds).<br><br>R16's medical record did not contain any documentation of the wound by the attending physician.<br><br>Review of R16's medical record did not demonstrate that the wound had been included in her Plan of Care.<br><br>Review of R16's medical record revealed a physician order, initiated 02/15/2026 and to start 02/16/2025), which stated, clean coccyx and right buttocks with normal saline. Then apply hydrophilic sound ointment to wound bed and cover with foam dressing change daily and PRN (as needed) in the afternoon for wound care.<br><br>On 03/04/2026 at 09:17 a.m. R16 was observed lying down in bed. Licensed Practical Nurse (LPN) S was observed explaining dressing procedure to R16. R16 was rolled to her left side with the assistance of Certified Nursing Aide (CNA) T. R16's brief was removed and no dressing was observed on R16's bottom. LPN S proceeded to cleanses R16's open wound, which was located to the left of<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | her coccyx, with normal saline. After cleansing of wound Director of Nursing (DON) B performed measurements of the wound. R16's open wound to the left of her coccyx was observed to be 1.4cm (centimeters) in length, 1.0 cm in width, and 0.1cm in depth. The wound bed was observed to be red with granulation tissue present. DON B verbalized that R16's wound was a stage 2 pressure ulcer. LPN S was then observed to apply hydrophilic wound ointment to wound bed and covered the wound with a foam dressing.<br><br>In an interview on 03/04/2026 at 10:04 a.m. Director of Nursing (DON) B explained that residents are assessed upon admission, and a complete skin assessment was completed within 24 hours. DON B explained that if a wound was present measurements would be recorded and a description of the wound be recorded. DON B explained that if the assessing nurse was a Registered Nurse then the wound would be staged appropriately. DON B explained that the attending physician would be contacted and a treatment order would be obtained. DON B explained that if a current resident was found to have any skin wounds that she was to be notified and she would ensure that the assessment was completed, the treatment was initiated, and the physician would view the wound and document appropriately. DON B explained that it was facility policy that skin sweeps are to be completed weekly. DON B explained if a resident had a skin wound that a Wound Assessment V2.1 document would be completed weekly. DON B explained that residents with skin issues and/or open wounds would be included in their plan of care.<br><br>DON B confirmed that R16 did not have a treatment order for her wound until 02/16/2026. DON B confirmed that R16 did not have a Weekly Skin Sweep document completed weekly. DON B confirmed that R16 did not have a Wound Assessment document completed when R16's wound was identified or completed weekly. DON B confirmed that R16's medical record had not revealed that the attending physician had recorded any documentation regarding R16's wound, progression of the wound, or treatment of the wound. DON B confirmed that R16's Care Plan did not include her stage 2 pressure ulcer or interventions to prevent or assist in the healing of the wound.<br><br>Resident #40 (R40)<br><br>Review of the medical record revealed R40 was admitted to the facility 10/03/2024 with diagnoses that included encephalopathy (a group of conditions that cause brain dysfunction), chronic respiratory failure, chronic obstructive pulmonary disease (COPD), type 2 diabetes, lung cancer, generalized edema (swelling cause by fluid in body tissue), heart disease, hypertension, depression, anemia (low red blood cells), myocardial infarction (heart attack), hyperlipidemia (high fat content in blood), cardiomegaly (enlarged heart), syphilis (an infection caused by bacteria), and cognitive communication deficit. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/03/2026, revealed R40 had a Brief Interview of Mental Status (BIMS) of 07 (severe cognitive impairment) out of 15.<br><br>During observation and interview on 03/01/2026 at 10:56 a.m. R40 was observed lying down in bed. R40 explained that staff would not give him his dentures. R40 then was observed opening his mouth and demonstrating that he had no teeth or dentures present. R40 explained that he would like to use his dentures. R40 could not explain where his dentures were in the room. No dentures were observed in R40's bedside dresser.<br><br>Review of R40's medical record revealed that he was currently receiving hospice benefits and was receiving Medicaid Services. Review of R40's medical record had not revealed that R40 had received any dental services. Review of R40's plan of care revealed a intervention, dated 11/25/2025, which (continued on next page) |

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| | 235538 | A. Building<br>B. Wing | 03/04/2026 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated Dentures: I have dentures, please assist me to ensure that they fit properly and are securely in place. Review of R10"s Kardex (document explaining care that was required to be provide by the bedside direct care givers.) revealed a section entitled Personal Hygiene/Oral Care which stated Dentures: I have dentures, please assist me to ensure they fit properly and a securely in place.<br><br>In an Interview on 03/02/2026 at 11:09 a.m. Certified Nursing Aide (CNA) U explained that R40 had dentures in the past. CNA U explained that when he had dentures in the past. CNA U explained that he currently had not used his dentures because they were loose fitting and R40 was choking on them. CNA U could not explain where R40's dentures were located.<br><br>In an interview on 03/02/2026 at 10:26 a.m. Director of Nursing (DON) B explained that it was her expectation that nursing staff would follow a resident's plan of care. DON B also explained that it was her expectation that a residents plan of care would be updated as necessary. DON B confirmed that R40's plan of care included a intervention, dated 11/25/2025, which stated Dentures: I have dentures, please assist me to ensure that they fit properly and are securely in place. DON B confirmed that R40's Kardex revealed a section entitled Personal Hygiene/Oral Care which stated Dentures: I have dentures, please assist me to ensure they fit properly and a securely in place. DON B could not explain why R40's plan of care was not being followed by the nursing staff. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to update/implement revisions for one resident (resident #46) and failed to ensure one resident (resident #7) along with resident #7's legal representative was afforded the opportunity to participate resident #7's care conference. Findings include: Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed Resident #7 was admitted to the facility on [DATE] with diagnoses that include dementia. R7 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). Further review of the clinical record revealed R7 had an activated Durable Power of Attorney (DPOA) for health care in place.<br><br>On 03/01/2026 at 10:36 AM, during an interview R7's DPOA expressed concern about lack of being informed and updated on R7's status. R7's DPOA further reported they lived out state and was originally told care conferences were held approximately every 90 days, but this had not been occurring.<br><br>On 03/02/2026 11:12 AM, during an interview with Social Worker (SW) D she reported she was responsible for arranging and inviting participants to care conference and further stated activated DPOA's would be included. SW D further stated care conferences were held within 72 hours, and then coinciding with the MDS/quarterly thereafter, and if residents or families opt not to participate the interdisciplinary team would still meet and discuss the residents plan of care and document the meeting/care conference in the residents' medical record.<br><br>R7's medical record was reviewed with SW D completed with SW D who agreed R7's quarterly MDS dated [DATE] did not have a coinciding care conference. SW D offered no explanation as to why a care conference was not held in February 2026.<br><br>Resident 46 (R46)<br><br>Review of the medical record reflected R46 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included acute respiratory failure with hypoxia, diabetes and acquired absence of the left leg, below the knee. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/12/26, reflected R46 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was at risk of developing pressure ulcers/injuries.<br><br>On 03/03/2026 at 3:28 PM, R46 was observed lying in bed, on their back, on a standard mattress. A wheelchair, at the right bedside, was noted to have a seating cushion in place. R46 stated before their initial admission to the facility, they had a rash on their bottom. R46 acknowledged a dressing was in place, on their bottom, which was changed the night prior. To R46's knowledge, the skin was not open or draining.<br><br>An Admission/readmission Assessment, dated 2/6/26, reflected non-blanchable (skin color does not fade when pressed on) redness to R46's sacrum.<br><br>A Nurse Practitioner Progress Note for 2/7/26 reflected, .Wound coccyx dressing order placed .<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R46's Care Plan, with a revision date of 1/15/26, reflected they were at risk for impaired or worsening skin integrity related to a healed scar and blanchable redness on the coccyx.<br><br>In an interview on 03/04/2026 at 10:04 AM, Director of Nursing (DON) B reported at the time of readmission from the hospital, on 2/6/26, R46 had non-blanchable redness on the sacrum, which indicated a stage one pressure ulcer was present. DON B acknowledged R46's Care Plan was not updated to reflect the presence of non-blanchable redness and still read as blanchable redness. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide person centered care to two dependent residents (R31, R55) out of three residents investigated for ALD's.Findings Include<br><br>Resident #31 (R31)<br><br>Review of the medical record reflected that R31 was admitted to the facility on [DATE]. Diagnoses of displaced Tri malleolar fracture of right lower leg, history of a stroke, polyneuropathy, obesity and rheumatoid arthritis.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2026 revealed R31 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively impact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R31 needed substantial assistance with showering and personal care. R31 was dependent on toileting, lower body dressing, and perineal hygiene.<br><br>During an observation and interview on 03/01/2026 at 8:57 AM, R31stated she had only received 1 shower since admission of 02/03/2026. R31 was in her hospital gown, hair was messy, matted in the back of her head. R31 stated she washed her hair a couple times a week at home before coming to the facility and she had not had her hair washed for more than a week.<br><br>During an interview on 03/02/2026 at 12:02 PM, CNA C stated they were able to get the residents showered, assist with brushing their teeth, wash their hands and face. CNA C stated if a resident refuses a shower, she would ask the resident 2 times and then let the nurse know. CNA C stated they do situations where the food trays come to the floor and it sit there until care is given. CNA C stated there is one CNA on this hall and she had three residents that are 2 person assist, so she would have to wait for someone from another call can help her transfer them.<br><br>Record review revealed R31 has had 3 bed baths in the last 30 days, but preferred showers. Record review did not have any refused shower or bath documentation. Care plan revealed R31 reported it was important for her to choose between a tub bath, shower or bed bath. Shower/Bathing/Bed Bath Scheduled- twice a week (Tuesday and Friday) and as needed. R31 did not receive her scheduled showers as scheduled.<br><br>During an interview on 03/02/2026 at 9:49, CNA Z and CNA Z stated sometimes they could meet resident's needs, they would ask other coworkers for help or schedule the showers on Saturday, because no showers are scheduled on Saturdays, only Sunday through Friday. If a resident refused, they would ask them 3 times if they want a shower and if they still refuse, then they tell the nurse. First thing they do on their shift is to get vital signs for the nurse, pass waters, pass breakfast trays, then get residents up for the day. CNA Z stated if therapy asked for residents to be up and around for therapy, they are put on the priority list and get up first. Both CNAs reported they have been mandated a lot in the last 6 weeks, and they do the best they can. Writer asked them if they know why R31 had not had a shower since her admission on [DATE], only 3 bed baths in the last 30 days? CNA Z stated she did not know, maybe she refused them. Writer asked if the resident refused, where would they document that? CNA Z stated it should be in the progress notes in their chart. Writer reported there was nothing in her chart/electronic medical record (EMR) stating she refused any showers. CNA's looked at each other and stated they didn't know then.<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #55 (R55)<br><br>Review of the medical record reflected R55 admitted to the facility on [DATE], with diagnoses that included lumbar region discitis (inflammation/swelling between spinal vertebrae), and sepsis due to Group B streptococcus (a type of bacteria). The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/26/26, reflected R55 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and required substantial/maximal assistance for showering/bathing and tub/shower transfers. According to the MDS, substantial/maximal assistance meant, Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.<br><br>On 03/01/2026 at 11:24 AM, R55 was observed seated in a standard chair, in their room. R55 reported they had not received a shower at the facility. R55 reported asking for a shower a couple times and being told it was not their shower day.<br><br>On 03/02/2026 at 10:13 AM, R55's Certified Nurse Aide (CNA) task documentation for scheduled shower/bathing/bed bath twice a week and as needed was reviewed and reflected documentation of a refusal on 2/27/26 at 9:59 PM. There was no further documentation pertaining to offered bathing or showers.<br><br>R55's Activities of Daily Living (ADL) Care Plan reflected interventions for 2/20/26 that included it was important to R55 to choose between a tub bath, shower or bed bath and for scheduled shower/bathing/bed bath twice weekly and as needed.<br><br>In an interview on 03/02/2026 at 1:27 PM, CNA E reported R55 was scheduled for showers on second shift, on Tuesday's and Friday's. CNA E reported they had heard from some residents that they did not receive their scheduled showers on second shift.<br><br>On 03/02/2026 at 1:39 PM, CNA E reported showers were documented in the CNA task charting for showers/bathing and on shower sheets.<br><br>On 03/02/2026 at 1:42 PM, R55's shower sheets, since admission, were verbally requested from Director of Nursing (DON) B.<br><br>On 03/02/2026 at 3:46 PM, DON B reported she could not find shower sheets for R55. DON B reported staff should have filled out a shower sheet and completed task documentation. DON B stated she reviewed R55's shower task and only noted documentation for a refusal for 2/27/26. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide meaningful activities to one resident (R31) out of one resident investigated.Findings IncludeResident #31 (R31)Review of the medical record reflected that R31 was admitted to the facility on [DATE]. Diagnoses of displaced Tri malleolar fracture of right lower leg, history of a stroke, polyneuropathy, obesity and rheumatoid arthritis.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2026 revealed R31 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively impact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R31 needed substantial assistance with showering and personal care. R31 was dependent on toileting, lower body dressing, and perineal hygiene.During an observation and interview on 03/01/2026 at 8:56 AM, R31 stated she doesn't get down to the activities because it took so much to get her up in her wheelchair and taken down there. Writer asked if the activity department brings her things to do in her room and she stated no. No observation of any activity's information, calendar or items visible in her room.During an interview on 03/03/26 at 7:49 AM, Activity Director (AD) AA stated they had four activities daily and the therapy department offers an exercise event on Fridays and everyone is invited. AD AA stated their hours are from 8:15am to 4:45pm. They cover the whole building, assisted living and long-term care. These hours were set up so they could help with breakfast trays in the morning, lunch trays and the dinner tray at the end of their day. First activity is at 9:00am, a word search, or provide one on one room visits, word puzzles, puzzles, crafts, magazines, books, activity is under task. Writer asked AD AA where they document which activities residents attend or the amount of time they spend on the one on ones. AD AA stated they cannot document the amount of time they spend with residents. AD AA added that they stop in the resident's room to check in on them throughout the week. AD AA stated they talk to other staff and if residents complain of being boarded but refuse everything, they note that. AD AA stated works closely with therapy department. Writer asked to look at the activity calendar for February and March.March calendar started out with a TV program first thing in the morning, no documentation on efforts with collaboration after tuning the TV on. Room visits do not reflect what the intent is or what they plan on doing during that visit. Resident Council meetings are listed as an activity. Popcorn cart delivering popcorn to residents was listed. The calendar did reflect an interactive activity with puzzles, church services, kitchen activities, bunco, card games, and crafts on certain days. Saturday activity was a game at 2:00pm and nothing else and Sunday activities were church and a game at 2:00pm. The calendar of events had a lot of times with no activities to do.During an observation and interview on 03/03/2026 at 9:39 AM, no observation of any activity materials visible in R31's room. R31 stated nobody had been in to talk to her about doing things that she would enjoy during her time at the facility.Record review revealed the care plan had a focus on having/offering therapeutic activities that support her rehab goals. R31's goal was to have her participate in leisure activities of interest almost daily. Interventions/task indicated that the following items were important to her including TV programs and news, cell phone use, social media, conversations and visits with family and friends. Please provide room supplies upon her request and encourage her to join groups of interest.State Operations Manual defines. Activities refer to any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent a significant weight loss for one resident (resident 5) of 2 reviewed from a total sample of 16.Findings include: Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed Resident #5 (R5) was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses dementia, depression, depression, Transient Ischemic Attack. R5 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status. On 03/01/2026 at 10:04 am, R5 was observed in his room, there was scrambled egg observed in two areas on the floor. R5 was sitting up in his wheelchair he was noted to have some tremors in both hands. When queried if he had breakfast yet, he replied he did but he didn't like it. R5 elaborated in great length that he wants oatmeal and asks for it every day, but depending on which Certified Nursing Assistant (CNA) is working he may or may not get it. When queried if he had met with Registered Dietician or the facility dietary manager R5 replied he doesn't know who they are. R5 stated his appetite was fair but he went from 140 pounds down to 118 because he does not get the foods that he likes. Further review of R5's clinical record revealed on 01/05/2026, the resident weighed 131.6 lbs. On 02/18/2026, the resident weighed 118.6 pounds, which is a -9.88% Loss. Review of Registered Dietician (RD) H assessment dated [DATE] revealed food preferences honored Further review of R5's clinical record revealed there was no documentation as to what R5's food preferences were. Review of R5's nutritional care plan dated 5/14/25 identified R5's beverage preference between meals was water but did not identify any likes or dislikes for meals or snacks. On 03/02/2026 at 10:05 AM, during an interview with CNA Q, she reported R5 was difficult to care for and that he needs help with eating because his hands and body shakes, and food falls to the floor but he refuses want assistance to be fed. CNA Q stated she believed R5 could benefit from weighted utensils. Hence the scrambled eggs observed on R5's floor that was observed the day prior. Review of Interdisciplinary Team (IDT) notes dated 2/26/26, revealed the IDT met to discuss R5's general decline, weight loss, behaviors .encouraging snacks and extra portions. R5's nutritional care plan dated 7/31/24 with revision date of 2/18/26 does not reflect extra portions or that snacks are to be encouraged. On 03/02/2026 at 12:35 PM, during an interview with RD H, she reported she was regional Dietician and came to the facility once a week. RD H reported R5 had a poor appetite, significant weight loss and that she had recommended supplements which were ordered by the physician. RD H stated she had not talked with or observed R5 eat since the significant weight loss. Review of R5's electronic medical record with RD H, resident food preferences were not documented in the medical record. RD H stated she put R5's food and drink preferences on his meal ticket. A copy of R5's meal ticket was requested and provided at that time and revealed R5 disliked salad there was nothing noted on what R5 liked or preferred. When queried why R5's clinical record or meal ticket had no likes or preferences, RD H stated they usually focuses on dislikes. When queried if she thought ensuring R5 food preferences should be met particularly with a 9.88% weight loss in one month RD H stated she didn't have a good answer. When quired if she attended or was part of the IDT meeting held on 2/26/26 RD H stated no she was not at the facility that day. On 03/04/2026 10:51 AM during an interview with Rehab Director W reported the therapy department trialed R5 with weighted utensils a few months ago and R5 did not like it. Requested copy of documentation related to R5's trial of weighted silverware, screening or evaluation that pertained to R5's ability to feed himself. Rehab Director W was unable to locate any documentation. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow Physician Orders for enteral (tube) feeding and accurately document enteral feeding acceptance for one (R1) of one reviewed.Findings include: Review of the medical record reflected R1 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included pneumonia, malignant neoplasm (cancerous tumor) of middle third of esophagus, unspecified severe protein-calorie malnutrition and gastrostomy status (surgical opening into the stomach). The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/30/26, reflected R1 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and received 51% or more of their total calories through parenteral of tube feeding. On 03/01/2026 at 11:48 AM, R1 was observed in bed, with the head of the bed elevated. They reported receiving bolus tube feeding (specified amount of feeding administered over a brief period of time) via feeding tube. R1 reported they were supposed to receive bolus feedings four times per day but believed the rate of the bolus feedings were too rapid, causing them to experience some diarrhea. On 03/02/2026 at 9:56 AM, R1 was observed lying in bed, with the head of bed elevated and their eyes closed. On 03/03/2026 at 10:16 AM, R1 was observed seated on the edge of their bed. When queried about tolerance of their bolus tube feedings, R1 acknowledged their tolerance had improved, and it was being administered slower, four times daily. A Progress Note for 2/26/26 at 10:08 AM reflected R1 requested to be changed to bolus feeding. The Registered Dietitian (RD) recommended discontinuing the current enteral nutrition order and starting [NAME] Farms Peptide 1.5, one carton (325 milliliters (mL)), four times daily, with a 100 mL water flush before and after. The note reflected the ordered amount provided 2000 kilocalories and 96 grams of protein. The February 2026 Medication Administration Record (MAR) reflected R1's bolus tube feedings were started on 2/26/26. The order reflected R1 was to receive bolus feedings of [NAME] Farms Peptide 1.5, one carton (325 mL), four times daily, with a 100 mL water flush before and after each bolus feeding. The MAR reflected refusal of the evening bolus feedings on 2/26/26, 2/27/26 and 2/28/26. Progress Notes for 2/27/26 at 12:32 PM and 12:33 PM reflected R1 had been requesting half the bolus feeding amount. The MAR reflected bolus feeding was administered as ordered for the afternoon of 2/27/26 and did not include an option to record the actual amount received. A Progress Note for 3/3/26 at 7:29 AM reflected R1 received 50 percent (%) of their morning bolus feeding due to refusing to accept the full amount. R1's March 2026 MAR reflected their bolus tube feeding of [NAME] Farms Peptide 1.5, one carton (325 mL), four times daily, with a 100 mL water flush before and after each bolus feeding was administered as ordered the morning of 3/3/26. The MAR did not include an option to record the actual amount received. In an interview on 03/03/2026 at 10:21 AM, Registered Nurse (RN) G reported R1 had switched from continuous feeding to bolus feeding the week prior. RN G stated R1 had been refusing their bolus feedings and only accepting approximately half of the ordered amount. RN G reported they administered half of R1's ordered bolus feeding that morning, per R1's request. RN G was unsure if the providers knew that R1 was not accepting the full amount of their ordered bolus feedings. A Progress Note for 3/3/26 at 10:58 AM reflected the Nurse Practitioner was notified of R1's acceptance of 50% of their bolus feedings. The note reflected they were advised to offer the bolus feeds as ordered and document the actual intake. In an interview on 03/03/2026 at 12:01 PM, RD H reported after returning from the hospital, R1 wanted to be on shakes or smoothies but was on a clear liquid diet. RD H stated R1 was refusing continuous tube feedings and agreed to bolus feeding. When asked if staff would notify her if R1 was not accepting the full amount of bolus feedings, RD H stated staff would document it. RD H stated if it was happening more continuously, staff should be notifying the provider. On 03/03/2026 at 12:30 PM, RD H reported following up with R1, who was agreeable to trying smaller<br>(continued on next page) |

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| | 235538 | A. Building<br>B. Wing | 03/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mission Point Health Campus of Jackson | 703 Robinson Road<br>Jackson, MI 49203 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | amounts of the bolus tube feedings, more times per day. RD H stated the last time she was notified of R1's tube feeding acceptance was when R1 wanted to switch to bolus feedings, which was the same day the bolus feedings were started (2/26/26). In an interview on 03/03/2026 at 12:59 PM, RN G reported administering two bolus tube feedings to R1 that day, with acceptance of approximately 50 percent (%). RN G stated the amount of tube feeding accepted was not measured. They stopped administration when R1 requested, and there was approximately 50% of the formula left in the carton. RN G stated they notified the Nurse Practitioner that day, who had not been made aware prior. R1's March 2026 MAR reflected their bolus tube feedings of [NAME] Farms Peptide 1.5, one carton (325 mL), four times daily, with a 100 mL water flush before and after each bolus feeding were administered as ordered on 3/1/26 and 3/2/26. The MAR did not include an option to record the actual amount received. In a phone interview on 03/03/2026 at 1:06 PM, Licensed Practical Nurse (LPN) I reported R1 had only been wanting half a bottle of their tube feeding at a time and was very adamant about not getting more. LPN I reported due to their shift times on 3/1/26, they administered two bolus feedings to R1 that day. LPN I reported R1 had an appointment on 3/2/26 and refused one of their bolus feedings. LPN I stated they administered two bolus feedings during their shift on 3/2/26. When asked about the MAR documentation, which reflected they administered three bolus feedings to R1 on 3/2/26, LPN I reported they must have made an error in their documentation and stated R1 absolutely did not get three bolus feedings on their shift that day. LPN I stated the amount of tube feeding accepted by R1 was not measured but was determined by eyeing and feeling the amount left in the carton. LPN I stated they had not personally notified a provider or the RD of R1's tube feeding acceptance, as they were told it had already been communicated by other nurses. R1's Progress Notes for 3/1/26 and 3/2/26 did not reflect refusal of the full amount of the ordered bolus tube feeding. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide dental services for two residents (#5, #40) out of three resident's review for dental services. Findings include: Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed Resident #5 (R5) was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses dementia, depression, depression, Transient Ischemic Attack. R5 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status.<br><br>On 03/01/26 at 10:00 am, during an interview with R5, he was observed sitting in his room in his wheelchair. R5 complained of mouth pain and was observed to have some missing teeth. R5 reported he's told several staff members that he needed to see dentist again due to the pain but hasn't gotten any response.<br><br>Review of the Physician order dated 01/07/26 reflected R5 was in need of a referral to oral surgeon, per dentist consult patient #20 tooth pain and causing sore on patient tongue.<br><br>On 03/02/2026 9:05 AM, during an interview with Social Worker D stated she doesn't handle referrals to an oral surgeon just the routine dental, podiatry. SW D further stated nursing would make those arrangements, possibly the Director of Nursing (DON) but not Social Work.<br><br>03/02/2026 9:13 AM during an interview with DON B she reported SW D would have been the one to make arrangements with the oral surgeon or possibly the Nurse Unit Manager who had recently resigned. Documentation was requested at that time and again on 03/05/26 there had been follow up on the Physician order for R5's oral surgeon was requested and not received by the end of the survey dated 3/06/26.<br><br>Resident #40 (R40)<br><br>Review of the medical record revealed R40 was admitted to the facility 10/03/2024 with diagnoses that included encephalopathy (a group of conditions that cause brain dysfunction), chronic respiratory failure, chronic obstructive pulmonary disease (COPD), type 2 diabetes, lung cancer, generalized edema (swelling cause by fluid in body tissue), heart disease, hypertension, depression, anemia (low red blood cells), myocardial infarction (heart attack), hyperlipidemia (high fat content in blood), cardiomegaly (enlarged heart), syphilis (an infection caused by bacteria), and cognitive communication deficit. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/03/2026, revealed R40 had a Brief Interview of Mental Status (BIMS) of 07 (severe cognitive impairment) out of 15.<br><br>During observation and interview on 03/01/2026 at 10:56 a.m. R40 was observed lying down in bed. R40 explained that staff would not give him his dentures. R40 then was observed opening his mouth and demonstrating that he had no teeth or dentures present. R40 explained that he would like to use his dentures. R40 could not explain where his dentures were in the room. No dentures were observed in R40's bedside dresser.<br><br>Review of R40's medical record revealed that he was currently receiving hospice benefits and was receiving Medicaid Services. Review of R40's medical record had not revealed that R40 had received<br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | any dental services. Review of R40's plan of care revealed a intervention, dated 11/25/2025, which stated Dentures: I have dentures, please assist me to ensure that they fit properly and are securely in place. Review of R10''s Kardex (document explaining care that was required to be provide by the bedside direct care givers.) revealed a section entitled Personal Hygiene/Oral Care which stated Dentures: I have dentures, please assist me to ensure they fit properly and a securely in place.<br><br>In an Interview on 03/02/2026 at 11:09 a.m. Certified Nursing Aide (CNA) U explained that R40 had dentures in the past. CNA U explained that when he had dentures in the past. CNA U explained that he currently had not used his dentures because they were loose fitting and R40 was choking on them. CNA U could not explain where R40's dentures were located.<br><br>In an interview on 03/02/2026 at 09:55 a.m. Social Worker (SW) D explained that she was responsible for the arrangement of dental services. SW D explained that dental services were provide by a visiting Dentist. SW D explained it was her responsibility to verify if the residents would like ancillary dental services and then provide a list of residents to the visiting dentist. SW D explained that she was not aware that R40 required dental services related to his dentures. SW D confirmed that a consent for dental services was not present in R40's medical record. SW D also confirmed that R40 had not every been seen by a dentist while at the facility. SW D could not explain why R40 had not been provide dental services.<br><br>In an interview on 03/02/2026 at 10:26 a.m. Director of Nursing (DON) B explained that dental services were coordinated by Social Services. DON B explained that nursing staff could report to Social Services if a resident needed dental services. DON B could not explain why R40 had not received routine dental services or dental services for loose fitting dentures.<br><br>Review of facility policy entitled Dental Services, implemented 10/17 and last revision date of 06/23, revealed Policy: It is the policy of this facility, in accordance with residents' needs, to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain complete and accurate medical records for one (R1) of 16 reviewed. Findings include:Review of the medical record reflected R1 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included pneumonia, malignant neoplasm (cancerous tumor) of middle third of esophagus, unspecified severe protein-calorie malnutrition and gastrostomy status (surgical opening into the stomach). The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/30/26, reflected R1 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and received 51% or more of their total calories through parenteral of tube feeding. On 03/01/2026 at 11:48 AM, R1 was observed in bed, with the head of the bed elevated. They reported receiving bolus tube feeding (specified amount of feeding administered over a brief period of time) via feeding tube. R1 reported they were supposed to receive bolus feedings four times per day but believed the rate of the bolus feedings were too rapid, causing them to experience some diarrhea. On 03/02/2026 at 9:56 AM, R1 was observed lying in bed, with the head of bed elevated and their eyes closed. On 03/03/2026 at 10:16 AM, R1 was observed seated on the edge of their bed. When queried about tolerance of their bolus tube feedings, R1 acknowledged their tolerance had improved, and it was being administered slower, four times daily. A Progress Note for 2/26/26 at 10:08 AM reflected R1 requested to be changed to bolus feeding. The Registered Dietitian (RD) recommended discontinuing the current enteral nutrition order and starting [NAME] Farms Peptide 1.5, one carton (325 milliliters (mL)), four times daily, with a 100 mL water flush before and after. The note reflected the ordered amount provided 2000 kilocalories and 96 grams of protein. The February 2026 Medication Administration Record (MAR) reflected R1's bolus tube feedings were started on 2/26/26. The order reflected R1 was to receive bolus feedings of [NAME] Farms Peptide 1.5, one carton (325 mL), four times daily, with a 100 mL water flush before and after each bolus feeding. Progress Notes for 2/27/26 at 12:32 PM and 12:33 PM reflected R1 had been requesting half the bolus feeding amount. The MAR reflected bolus feeding was administered as ordered for the afternoon of 2/27/26 and did not include an option to record the actual amount received. A Progress Note for 3/3/26 at 7:29 AM reflected R1 received 50 percent (%) of their morning bolus feeding due to refusing to accept the full amount. R1's March 2026 MAR reflected their bolus tube feeding of [NAME] Farms Peptide 1.5, one carton (325 mL), four times daily, with a 100 mL water flush before and after each bolus feeding was administered as ordered the morning of 3/3/26. The MAR did not include an option to record the actual amount received. In an interview on 03/03/2026 at 10:21 AM, Registered Nurse (RN) G reported R1 had switched from continuous feeding to bolus feeding the week prior. RN G stated R1 had been refusing their bolus feedings and only accepting approximately half of the ordered amount. RN G reported they administered half of R1's ordered bolus feeding that morning, per R1's request. In an interview on 03/03/2026 at 12:59 PM, RN G reported administering two bolus tube feedings to R1 that day, with acceptance of approximately 50 percent (%). RN G stated the amount of tube feeding accepted was not measured. They stopped administration when R1 requested, and there was approximately 50% of the formula left in the carton. R1's March 2026 MAR reflected their bolus tube feedings of [NAME] Farms Peptide 1.5, one carton (325 mL), four times daily, with a 100 mL water flush before and after each bolus feeding were administered as ordered on 3/1/26 and 3/2/26. The MAR did not include an option to record the actual amount received. In a phone interview on 03/03/2026 at 1:06 PM, Licensed Practical Nurse (LPN) I reported R1 had only been wanting half a bottle of their tube feeding at a time and was very adamant about not getting more. LPN I reported due to their shift times on 3/1/26, they administered two bolus feedings to R1 that day. LPN I reported R1 had an appointment on 3/2/26 and refused one of their bolus feedings. LPN I stated they<br>(continued on next page) |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | administered two bolus feedings during their shift on 3/2/26. When asked about the MAR documentation, which reflected they administered three bolus feedings to R1 on 3/2/26, LPN I reported they must have made an error in their documentation and stated R1 absolutely did not get three bolus feedings on their shift that day. LPN I stated the amount of tube feeding accepted by R1 was not measured but was determined by eyeing and feeling the amount left in the carton. R1's Progress Notes for 3/1/26 and 3/2/26 did not reflect refusal of the full amount of the ordered bolus tube feeding. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to effectively maintain the resident call system for 2 (R21, R55) of 16 sampled residents affecting 2 residents, resulting in the increased likelihood for resident negative outcomes related to delayed and/or no emergency response.Findings include:Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] BIMS of 14, revealed Resident #21 was a [AGE] year-old female admitted on [DATE] with diagnosis of dysphonia (impairment in voice production, characterized by hoarseness, breathiness, strain or breaks in voice quality) depression and anxiety.<br><br>On 03/01/2026 at 2:17 PM, the call light was tested in R21's (room and bathroom) with another surveyor. While testing the call light, Director of Nursing (DON) B brought in a [NAME] bell and handheld service bell and placed in on R21's overbed table. Interview with Licensed Practical Nurse (LPN) V stated the bathroom light should light up red. When the cord was pulled there was no noted change in color of the light. When queried if there was a panel somewhere, possibly the nurses' station, that would notify staff what call light was on in what room, LPN V said they used to have that, but it got taken out about one year ago.<br><br>On 03/01/2026 at 2:44 PM, while in R21's room with DON B and another surveyor present, R21 was observed in bed, the nightstand was behind R21 and was not in reach to open the drawers or reach on top of the drawers. DON B queried R21 to where the handheld bell and [NAME] bell was from last week. R21 reported in a soft voice They moved it. DON B replied Oh you moved it? R21 stated No and again reiterated that staff moved the bells out of reach.<br><br>Resident #55 (R55)<br><br>On 03/01/2026 at 11:37 A.M., the call light system was observed not working as designed, within resident R55s room. The corridor visual light was observed dimly lit. The audible signal was also observed providing extremely low volume.<br><br>On 03/01/2026 at 1:04 P.M., an interview was conducted with Environmental Services Director (ESD) K regarding the facility call system, within resident R55s room. ESD K stated that the duty station (audible enunciator) is located at each nursing station, they have the lights in the hallway, and that the system has a visual and an audible component.<br><br>On 03/01/2026 at 1:15 P.M., the resident call system duty station (audible enunciator) was observed located within the Medication Room of each neighborhood (100 Hall, 200 Hall, and 300 Hall) nursing station.<br><br>On 03/01/2026 at 1:20 P.M., an interview was conducted with (ESD) K regarding the specifications of the current resident call system. (ESD) K stated that the current system is a hard-wired system that was installed in 2010 and went obsolete in 2020. (ESD) K further stated that Resident rooms R21 and R55 are currently experiencing the same issue.<br><br>On 03/01/2026 at 1:25 P.M., an interview was conducted with R21 regarding her resident call system. R21 stated that they have to go out into the corridor to find someone to help me them. R21 was observed to be on oxygen and with reduced ambulation skills.<br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/01/2026 at 2:18 P.M., an interview was conducted with (ESD) K regarding the facility resident call system. (ESD) K stated that the call system has been obsolete since 2021 and that they have attempted to change faulty components for repair. (ESD) K additionally stated that the interventions used if there were to be a system failure would be to use bells in each room; one is a hand-held tambourine style, and the other is a stem type bell. (ESD) K was queried regarding the call light system functionality and stated that when the bathroom call system is activated, the outside visual will turn red. (ESD) K also stated that the visual for rooms for R 55 and R 21 is currently a faint red. (ESD) K was queried regarding when the call light system functionality failure had occurred and replied that it was late December 2025 or early January 2026.<br><br>On 03/01/2026 at 2:58 P.M., an interview was conducted with Certified Nursing Assistant (CNA) Q regarding the resident call system, within resident room [ROOM NUMBER]. (CNA) Q stated that the call system failed in late December 2025.<br><br>On 03/01/2026 at 3:00 P.M., an interview was conducted with (ESD) K regarding the resident call system. (ESD) K stated that the call light in resident R21 room had a work order initiated on January 8th and again on February 18th.<br><br>On 03/01/2026 at 3:25 P.M., an interview was conducted with R21 regarding her restroom call light system. When queried if they use the restroom, R21 stated yes. When queried how they would summons emergency help if they were in the restroom, R21 stated they would pull the cord for help. R21 further stated: Sometimes it takes a long time to get help.<br><br>On 03/01/2026 at 3:44 P.M., an interview was conducted with (ESD) K regarding the facility resident call system work order generated for residentR55 room (dated 8/4/17). (ESD) K stated that the call system failed for resident R55s room on January 22nd and that they placed a jingle bell (hand-held tambourine) in resident R55s room on January 22nd. (ESD) K additionally stated that the call system failed for resident R 21s room on January 8th and they had nursing place a stick bell in the room on January 8th.<br><br>On 03/02/2026 at 9:06 A.M., an interview was conducted with Executive Director A regarding the facility call light system. Executive Director A stated that they are moving both residents from their current rooms to rooms with functioning call light systems.<br><br>On 03/04/26 at 07:00 A.M., record review of the Policy/Procedure entitled: Resident Call System dated 1/11/2021 revealed under Policy: (Name of Facility) is committed to following a proper procedure for resident, staff, and visitor safety. Record review of the Policy/Procedure entitled: Resident Call System dated 1/11/2021 also revealed under Purpose: To ensure the facilities call system is designed, constructed, equipped, and maintained to protect the health and safety of the residents. Record review of the Policy/Procedure entitled: Resident Call System dated 1/11/2021 further revealed under Procedure: The facility will be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside, toilet, and bathing facilities. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation and interview, the facility failed to ensure the daily nurse staffing information was accurately posted for each shift in accordance with State Operations Manual, Appendix PP. Findings include: The facility staffing that was observed posted on 03/01/2026 09:10 AM was dated 2/27/26. On 03/03/2026 at 10:43 AM, during an Interview with Director of Nursing (DON) B stated new scheduler should have put posted the staffing for the weekend on Friday before she left. When queried how that could be done i.e., residents being transferred to the hospital, discharged home, staff call ins etc . It was queried who was responsible for the posting on the weekends. DON B stated she would have to review and then devise a plan. |