STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235549	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Park Nursing and Rehabilitation Communit	1300 West Broadway Avenue Muskegon, MI 49441

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure that they had Registered Nurse (RN) coverage for at least 8 consecutive hours a day for 1 of 30 days (3/8/26) reviewed for RN coverage. Findings include: A review of the Daily Staffing sheets, dated 3/1/26 to 3/30/26, revealed the following that on Sunday 3/8/26 the facility had no RN coverage listed for that day. During an interview on 04/02/2026 at 10:30 AM, the Nursing Home Administrator (NHA) stated that she did not know why the Daily Staffing sheet for 3/8/26 did not include RN hours. She stated her Payroll Based Journal (PBJ) Staffing Data Report showed she had RN coverage for that day. The NHA stated that the staffing sheets that she provided to the survey team were the ones that they start the days with and if there was a change to the staffing sheets, it should be reflected on it. The NHA stated she did not know why the staffing sheet for 3/8/26 was not changed to reflect RN coverage. A copy of the facility's PBJ Staffing Data Report for 3/8/26, nursing working schedule with the actual hours worked by staff for 3/8/26, and the time sheets for the nurses for 3/8/26 was requested from the NHA. The NHA verbally confirmed the request. As of the completion of the survey and exit from the facility, the facility failed to provide any documentation that would reflect that they had RN coverage on 3/8/26.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment affecting 34 residents, resulting in the increased likelihood for cross-contamination, equipment failure and harborage conditions. Findings include:On 03/31/2026 at 9:05 AM, upon entering the kitchen for the initial tour [NAME] X revealed that the Dietary Manager had come in this morning, tossed his keys on his desk then stated he quit, he was done. We have someone coming to help us but right now, I'm in charge. [NAME] X was able to demonstrate knowledge. The Raetone and True Cooler Units were observed to have torn and improperly fitting door seals. Observation hood system revealed the light fixture located inside the hood system was not working resulting in insufficient amount of lighting to staff while they cooked. Further observation revealed the toggle switch that was used to turn on/off the lights was broken clean off the outside of the hood system. Review of the FDA 2017 Food Code Section, 4-501.11 Good Repair and Proper Adjustment. Reflects the following, (A) Equipment shall be maintained in a state of repair and condition that meets the requirements under 4-1 and 4-2. (B) EQUIPMENT components, such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications.Observation of the can opener blade and the housing unit for the can opener reflected stuck on food residue and debris. Observation of the dish machine revealed it was dirty, soiled, with an accumulation of build-up on the top of the machine.Observation of the cooler and freezer units located throughout the kitchen were observed to have build-up of dust, mold, and food debris on the doors, door seals, fans and fan grates, shelving, bottoms, sides, handles and tops of the units.Review of the FDA 2017 Food Code Section, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces and Utensils. Reflects the following, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean sight to 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.The flooring throughout the kitchen, hallways in the kitchen and storage areas were observed to have a build-up of dust, dirt, food debris, and general garbage on the floor.Review of the FDA 2017 Food Code Section, 6-501.12 Cleaning, Frequency and Restrictions. Reflects the following, (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. Observation of the hood system revealed the filters were dusty, dirty, and had an accumulation of build-up. Review of the FDA 2017 Food Code Section, 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition. Reflects the following, (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials.Observation of the water lines on the Coffee and Juice Machines reflected that they did not have any backflow prevention. Further review of the coffee and juice machines reflected they were not connected to a water filter. Review of the FDA 2017 Food Code Section, 5-203.14 Backflow Prevention Device, When Required. Reflects the following, A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas containment into the water supply system at each point of use at the FOOD ESTABLISHMENT, including on a hose bib if a hose is not attached and backflow prevention is required by LAW, by: . (B) Installing an APPROVED backflow prevention device as specified under 5-202.14. Review of the FDA 2017 Food Code Section, 5-202.15 A water filter, screen, and other water conditioning device installed on water lines shall be designed to facilitate disassembly for periodic servicing and cleaning. A water filter element shall be of the replaceable type.During a follow-up visit of the kitchen on 3/31/26 at 11:55 AM, Regional Dietitian (RD) O confirmed that the Dietary Manager quit this morning. RD O revealed she would be working on getting things cleaned up, changing the menus out, and making the necessary repairs and finding a replacement for the Dietary Manager.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow policies and procedures for enhanced barrier precautions (EBP), hand hygiene, and monitoring for infection control practices for 2 (R14 and R24) of 2 residents reviewed for infection control. Findings include: Review of a Face Sheet revealed R14 originally admitted to the facility on [DATE] and had pertinent diagnoses of hemiplegia and hemiparesis (one-sided weakness), vascular dementia, and blindness in right eye. Review of the Care Plan revealed R14 is severely cognitively impaired. Review of the Care Plan revealed R14 received tube feedings and required enhanced barrier precautions (EBP) related to his feeding tube. R14 was also incontinent of bowel and bladder. During an observation and an interview on 3/31/26 at 1:35 PM, Certified Nursing Assistant (CNA) G started to provide incontinence care for R14 without the appropriate personal protective equipment. CNA G proceeded to provide care with her long hair hanging down touching the bed and the resident. When CNA G finished with peri-care, she used the same gloves to adjust the oxygen nasal cannula in R14's nose, repositioned his pillow and blankets, the bed remote and other close tangible items. CNA G then took off her gloves and transported the soiled linen down the hallway to the soiled utility. No hand hygiene was completed before leaving the room. In an interview on 3/31/26 at 2:03 PM, CNA G reported she was nervous when she was observed providing care for R14 and forgot to put on the appropriate PPE and perform hand hygiene after providing incontinence care. In an interview on 3/31/26 at 2:31 PM, the Director of Nursing (DON) and the Regional Nurse Consultant (RN) A reported hand hygiene should be done every time after providing incontinence care and moving from dirty to clean surfaces. Hand sanitizer is available outside the rooms and should be used after removing gloves and leaving the resident rooms. RN A reported the facility is to be doing audits for infection control practices on a weekly basis for all departments. In an interview with the Assistant Director of Nursing/Licensed Practical Nurse (LPN) I reported she was to do the infection control monitoring audits and provided the audits for December 2025 to February 2026. Review of these documents provided revealed only enhanced barrier precautions were audited. LPN I reported she did all the audits on one day each month. When questioned about other infection control monitoring and education such as hand hygiene, LPN I reported she had no other audits or documented staffing education. Review of a Hand Washing/Hand Hygiene policy last reviewed on 1/2025 revealed: Practicing Hand Hygiene is a simple effective way to prevent infections by preventing the spread of germs. Wash hands and other skin surfaces when: 1. After immediate contamination with blood, other body fluids or potentially contaminated articles; 2. After removing gloves or other personal protective equipment; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. After care of each resident; . Education and Training All staff will be provided with education during new hire orientation. Annual education will be provided, Infection Control & Hand Hygiene Procedure Reminders in the Workplace such as: Postings of Procedural Practices, Visual Prompts, and campaigns. Review of the Enhanced Barrier Precautions policy last reviewed 1/2025 revealed: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 1. Prompt recognition of need: a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. e. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. 4. High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, etc. h. Wound care: any skin opening requiring a dressing (may exclude shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing). 5. Enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high-contact activity. Review of the Infection Control Program policy last reviewed 1/2025 revealed: The major purposes of Infection Control Programs in the nursing facility are to minimize the effects of infections on residents and employees, and to educate the staff. A successful Infection Control Program requires an underlying commitment and facility-wide participation. It should not just be seen as a way to meet paperwork requirements but as a way to analyze and use information effectively to improve care and prevent problems. Elements of an Infection Control Program The elements of an infection control program consist of; coordination/oversight policies/procedures surveillance antibiotic stewardship program outbreak management prevention of infection employee health and safety The Centers for Medicare & Medicaid Services (CMS) require the long term care facilities to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. During an observation on 03/31/2026 at 7:45 AM, Licensed Practical Nurse (LPN) D poured R24's medications into her bare hand (no gloves) and handed them to R24 two, three, or four tablets at a time depending on the size of each tablet. LPN D stated R24 preferred to be handed the tablets individually versus all at the same time in a medication cup. LPN D was not observed washing/sanitizing her hands prior to, or following, administering R24 her medications. During an interview on 03/31/2026 at 3:30 PM, the Director of Nursing (DON) stated nurses are not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	supposed to handle medications with their bare hands. He also stated they are supposed to wash their hands between residents when they are administering medications. During an interview on 04/02/2026 at 8:15 AM, Registered Nurse (RN) E stated nurses should not handle medications with their bare hands. He stated if they did it would be an infection control issue. A review of the facility's Hand Washing/Hand Hygiene policy and procedure, reviewed 01/2025, revealed, Policy: Practicing Hand Hygiene is a simple effective way to prevent infections by preventing the spread of germs. Wash hands and other skin surfaces when. 3. After care of each resident; 4. Before and after nursing treatments or procedures (dressing changes, catheter insertion, eye drop instillation, etc.). A review of the facility's Medication Administration Procedures, dated 4/2020, revealed, C. Administration. 2. Do not touch any tablets or capsules with fingers. Maintain sanitary techniques during medication administration.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor a resident's desire for showers for 1 of 1 resident (R6) reviewed for choices. Findings include: A review of R6's Face Sheet, dated 4/1/26, revealed they were an [AGE] year-old resident admitted to the facility on [DATE]. In addition, R6's Face Sheet revealed they had multiple diagnoses that included depression and generalized muscle weakness. A review of R6's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 2/4/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R6 was cognitively intact. In addition, R6's MDS revealed they needed supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for showers. During an interview on 03/31/2026 at 9:30 AM, R6 stated she does not get showers often. She stated she and her resident advocate have been fighting them over getting showers for a while. In addition, R6 stated she goes without showers for weeks. A review of the [NAME] End Shower Schedule, updated 3/1/2023, revealed showers were scheduled by room number and divided between morning and evening (AM and PM) shifts. The [NAME] End Shower Schedule revealed R6 was supposed to receive showers twice a week on Tuesdays and Thursdays during the AM shift (in the morning). A review of R6's electronic medical record (EMR), dated 10/30/25 to 3/31/26, revealed R6 had Skin Monitoring- CNA/STNA (Certified Nursing Assistant/State Tested Nurse Aide) Shower Review sheets for 12/24/25, 12/27/25, 1/3/26, and 1/8/26. During a second interview on 03/31/2026 at 11:55 AM, R6 stated she just received a shower. She stated she feels fresh. A review of the Resident Council Minutes, dated 11/18/25 to 3/26/26, revealed the following: - 11/18/25= Showers- not getting done- for example today [name of Resident #6] wasn't asked if she wanted a shower. Last shower was at 10 pm- she wants it earlier. - 12/16/25= Old Business: Showers being given. No. - 1/13/26= Old Business: Showers being given- No. Still No. - 2/17/26= Old Business: Showers- major improvements. - 3/24/26= Old Business: Showers- major improvements. New Business: Showers- not being offered. [Name of Resident #6]- over a week since she has been offered one. Feels she has to beg for a shower. A review of R6's progress notes, dated 10/30/25 to 03/31/2026 revealed the following: - Licensed Nurse (LPN/RN) note, dated 3/22/26, revealed, Pt's (patient's) daughter came to this nurse, telling this nurse that her mother has not had a shower since last week Saturday and that is not acceptable. She stated a CNA had told either her or resident that they have been short staffed and that is why she hasn't gotten her shower. Residents daughter stated she would be coming in to speak to management on this matter. During an interview on 03/31/2026 at 3:00 PM, RN A stated she looked at R6's Skin Monitoring- CNA/STNA Shower Review sheets, dated 03/01/2026 to 03/31/2026, and knows the facility has an issue with providing showers and/or documenting showers that were provided. During an interview on 04/01/2026 at 11:10 AM, R6's Skin Monitoring- CNA/STNA Shower Review sheets, dated 11/01/2025 to 02/28/2026, were requested from the Nursing Home Administrator (NHA). In addition, the NHA stated she had provided all R6's Skin Monitoring- CNA/STNA Shower Review sheets for March 2026 that they could locate to the survey team. During an interview on 04/02/2026 at 7:58 AM, Assistant Director of Nursing (ADON) I stated that R6's Skin Monitoring- CNA/STNA Shower Review sheet, dated 6/14/26, was actually the shower review sheet from 03/14/2026 since it was in the shower review sheet book kept at the nurse's station with R6's other shower review sheets for March 2026. She stated she does not know why it was 6/14/26 but would talk to the nurse about it. A review of R6's Skin Monitoring- CNA/STNA Shower Review sheets that the facility provided, dated 11/01/2025 to 03/31/2026, revealed R6 had a shower on 1/21/26, 3/14/26 (labeled 6/14/26), 3/19/26, and 3/24/26. Therefore, based on the Skin Monitoring- CNA/STNA Shower Review sheets that the facility (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided, the Skin Monitoring- CNA/STNA Shower Review sheets that were scanned into R6's EMR, the Resident Council Minutes mentioned above, and the interview with R6 on 03/31/2026 at 11:55 AM, R6 only received eight showers between 11/01/2025 and 03/31/2026 even though R6 (and her family) had informed the facility as early as 11/18/25 that she was not receiving her scheduled showers.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure licensed nurses followed professional standards of practice related to medication storage, medication administration, medication administration documentation, and treatment documentation for 4 residents (R2, R14, R110 & R111) out of 24 residents reviewed for professional standards. Findings Include: R14Review of a Face Sheet reflected R14 admitted to the facility with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, epilepsy, dysphagia following cerebral infarction (difficulty swallowing after a stroke), gastrostomy (feeding tube) and contractures. During an observation on 6/3/26 at 8:50 AM, Certified Nurse Aide (CNA) C and CNA D entered R14's room to assess his need for a brief change. R14 did not have bilateral palm protectors in place, and R14's left eye was matted with thick drainage. During the observation, CNA C attempted to place a palm protector (hand splint) in R14's left hand before cleaning R14's hand. R14's fingernails were long with sharp edges. CNA C was unable to place the palm protector in the left hand and instead put a rolled washcloth in its place. When CNA C gathered supplies to complete a brief change for R14, she was unable to locate baby wipes in R14's room and used washcloths to clean R14. CNA C was also unable to locate baby shampoo, also known as facility stock body wash. Review of a Care Plan initiated on 7/02/2024 reflected R14 was dependent on staff for ADLs. The care plan indicated R14 needed Bilateral palm protectors on in AM and off in PM. Hand hygiene completed prior to donning and after doffing. If palm protectors are soiled, handwash in sink and let dry. Report any skin irritation; Family preference to use baby wipes with all peri care. Family to provide wipes; status of transfers: Hoyer lift with 2 assist. The ADL care plan did not address bathing or showering. Further review of the entire care plan did not address bathing or showering needs and preferences. A footnote was noted in the care plan that reflected Evaluation Note: 8/12/2024, (name of former Director of Nursing) encourage (R14) to get up daily out of bed. Use hoyer and sits in geri-chair. R14 was not observed out of bed for the duration of the survey conducted 6/3/26 from 7:30 AM – 3:30 PM. Review of the Medication Administration Record (MAR) for June 2026 reflected the following orders:-Baby shampoo Eye Wash BID (twice a day).-Please use baby wipes provided by the family for peri-care.-(R14) is to be up in the Broda chair every M-W-F (Monday, Wednesday, Friday) Nurse to sign off that he is up, if not document the reason he is not. (6/3/26 is a Wednesday)-Apply bilateral palm protectors in AM after performing hand hygiene. Remove in PM All of the above orders had been documented as completed by Licensed Practical Nurse (LPN) A, as evidenced by LPN A's initials on the MAR for 6/3/26, despite observations to the contrary. During an observation on 6/3/2026, at 8:43 AM, Licensed Practical Nurse (LPN) A was observed walking away from the East Hall medication cart. The lock to the medication cart was not engaged and the drawers were unlocked. The lockable cover/lid of the narcotic compartment in the second drawer on the right side of the cart was not locked as evidenced by the cover lifted up when the drawer was opened. Upon opening the medication drawer for stock/over the counter medications, several stock medications were observed with the lids off, the medication containers were open to air and potential spillage. The top drawer of the medication cart held an oval tablet in a plastic (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication cup without a label or name on the medication cup. There was a paper medication cup stacked on top of another cup with two dark round tablets. The top paper medication cup read iron without a resident name or room number. An orange retail pharmacy prescription container without any label was observed in the top drawer. Several tablets of varying size and color were observed in the unlabeled prescription bottle. LPN A reported that the unlabeled prescription bottle belonged to her. The medication cart was then locked, and LPN A was instructed to unlock the medication cart. LPN A retrieved the East Hall Medication Cart keys, that included the key to the narcotic box within the medication cart, from an open pink plastic container on top of the medication cart. During an interview on 6/3/2026 at 8:46 AM, LPN A reported the unlabeled prescription bottle in the medication cart belonged to her. LPN A did not have an explanation for why the East Hall medication cart keys were left unsecured on top of the medication cart rather than on her person. LPN A did not explain why the stock medications were uncovered without the lids on them in the drawer of the medication cart. During an interview on 6/3/2026 at 9:20 AM, Registered Nurse (RN)/Regional Nurse Consultant E reported that the standard practice at the facility is the licensed nurse would not store personal belongings in a medication cart, would not store unlabeled, preset medications and would be sure to secure the medication cart at all times, keeping controlled substances under double lock and key. Legal Guidelines for Documentation. Errors in recording can lead to errors in treatment or may imply an attempt to mislead or hide evidence. Record must be accurate, factual, and objective. Be certain that each entry is thorough. A person reading your documentation needs to be able to determine that a patient received adequate care. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 366). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Negligence occurs when a nurse had a duty of care that is breached, a patient is physically harmed, and damages are provided to make the person whole; a reasonably prudent nurse under similar circumstances would have done care differently. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 319). Elsevier Health Sciences. Kindle Edition. Resident #2 (R2) Review of an admission Record revealed R2 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: kidney disease and lymphedema. Review of R2's Order Summary dated 5/27/26 revealed, hydrocodone-acetaminophen (Norco) 10-325 mg tablet Every 6 Hours-PRN (as needed). Review of R2's Medication Administration Record revealed a dose of Norco was administered on 5/28/26 at 4:09 PM. Review of R2's Controlled Substances Proof of Use form revealed no documentation that a dose of Norco was dispensed on 5/28/26 at 4:09 PM. Review of R2's Electronic Medical Record revealed no documentation pertaining to Norco administration on 5/28/26 at 4:09 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #110 (R110) Review of an admission Record revealed R110 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia with behavioral disturbances. Review of R110's Order Summary dated 5/30/26 lorazepam (Ativan) 0.5 mg tablet As Needed (no repeat interval was indicated on the order).Per on-call (name omitted) ok to add back onto medication list. Indicating the previous order dated 5/10/26-5/19/26 lorazepam (Ativan) 0.5 mg tablet Every 8 Hours-PRN was to be reinstated. Review of R110's Controlled Substances Proof of Use form revealed a dose of Ativan was dispensed on 5/30/26 at 4:43 PM and 5/30/26 at 7:26 PM. Review of R110's Medication Administration Record revealed a dose of Ativan was documented as administered on 5/30/26 at 4:45 PM and 5/30/26 at 7:26 PM (2 hours and 41 minutes between doses). Review of R110's Electronic Medical Record revealed no documentation for the rationale for the doses of Ativan being administered less than 3 hours apart. Resident #111 (R111) Review of an admission Record revealed R111 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: heart failure, lymphedema, and anxiety. Review of R111's Order Summary dated 1/29/26 revealed, alprazolam (Xanax) 0.5 mg tablet Twice A Day. To be administered in the morning and in the evening. Review of R111's Controlled Substances Proof of Use form revealed on 6/1/26 only 1 dose of Xanax was documented as dispensed (7:32 AM). Review of R111's Medication Administration Record revealed on 6/1/26 both the morning and evening dose of Xanax were documented as administered. Review of R111's Order Summary dated 1/29/26 revealed, hydrocodone-acetaminophen (Norco) 5-325 mg tablet Every 6 Hours-PRN. Review of R111's Controlled Substances Proof of Use form revealed a dose of Norco was dispensed on 6/2/26 at 9:45 PM. Review of R111's Medication Administration Record revealed no documentation that the dose of Norco was administered. Review of R111's Electronic Medical Record revealed no documentation for the rationale of the withholding of R111's Xanax in the evening of 6/1/26 or Norco in the evening of 6/2/26. During an interview on 6/3/26 at 2:56 PM, Regional Nurse (RN) I confirmed the medication errors and documentation discrepancies for R2, R110, and R111. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/3/26 at 3:15 PM, during the exit conference, RN I confirmed the expectation was that the licensed nurses were expected to follow professional standards of nursing practice and the rights of medication administration. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Professional standards such as Nursing: Scope and Standards of Practice (American Nurses Association [ANA], 2021) apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications .1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide activities for 1 (R14) of 1 resident reviewed for activities.Findings include:Review of a Face Sheet revealed R14 originally admitted to the facility on [DATE] and had pertinent diagnoses of hemiplegia and hemiparesis (one-sided weakness), vascular dementia, and blindness in right eye. Review of the Care Plan revealed R14 is severely cognitively impaired. During an observation on 3/30/26 at 9:49 AM, R14 was lying in bed in his room. In an interview on 3/30/26 at 12:31 PM, the Guardian of R14 reported she had concerns of R14 being in bed all day and not attending activities. R14 liked religious activities like singing gospel songs and church activities. The Guardian reported R14 had not had a care conference in at least 6 months. During an observation on 3/31/26 at 9:16 AM, R14 was observed sleeping in bed. During an observation on 3/31/26 at 10:09 AM, R14 was lying in bed. During an observation on 3/31/26 at 11:40 AM, R14 was still in bed. During an observation on 3/31/26 at 1:07 PM, R14 was still in bed. In an interview on 3/31/26 at approximately 4:00 PM, Registered Nurse (RN) reported that R14 does not like to get out of bed and is scheduled to be out of bed on Mondays, Wednesdays, and Fridays. During an observation and an interview on 3/31/26 at 1:35 PM, R14 was lying in bed. Certified Nursing Assistant (CNA) G reported R14 only gets out of bed on Wednesdays and Saturdays. Review of the Care Plan for R14 revealed: - ADL Functional Status Care Plan dated 7/2/24- Goal-Approach: Staff assist and encourage to get up in the broda chair daily.- Enhanced Barrier Precautions Care Plan (EBP) (which did not reflect EBP and instead addressed activities of daily living) - tends to be passive or refuse group activities dated 6/10/24. If he is up in his broda chair he is more likely to come down to an activity, but he does not always like getting out of bed. Staff will encourage [R14] to get up in his chair daily but will respect his wishes if he chooses to stay in bed to watch TV channel 22 Westerns or sports. Approaches included: Res to watch sports or westerns channel 7 preferred by resident or guardian, initiated 7/3/25. Activity director will do quarterly re eval of [R14's] participation/satisfaction with their personal routine/activities, initiated 6/10/24. Encourage [R14]to attend musical programs, initiated 6/10/24. Encourage/invite [R14] to activities that suit their interest or is compatible to their prior life interests/hobbies. He enjoys going outside, listening to music, being around others, watching tv/movies, games, ect., initiated 6/10/24. Offer 1-1 visits PRN to provide companionship as [R14] is able to tolerate. Offer activities such as reading poetry or scripture, gentle hand massages, reminiscing/storytelling, singing, listening to music, looking at photographs, etc., initiated 6/10/24. Offer [NAME] a variety of materials such as books, magazines, puzzles, coloring books, cards, etc., initiated 6/10/24. Place monthly activity calendar in [NAME]'s room so family/friends/staff may also look for an activity they feel [NAME] might enjoy. When of interest [R14] enjoys, musical activities, watching bingo, going outside, sitting in the activity room, movies, tv, ect., initiated 6/10/24. Respect [R14's] right/wishes if they choose to decline attending a particular activity, initiated 6/10/24. Staff will assist transporting [R14] to/from activities as needed, initiated 6/10/24. -No care plan indicating R14 was to get out of bed on Mondays, Wednesdays and Saturdays. In an interview on 4/1/26 at 12:11 PM, Activities Director (AD) R reported R14 had not been involved in the facility activities in over a year. When questioned about attending religious activities like singing, AD R reported R14 does like to sing. AD R reported R14 refuses activities but did not have any documentation where activities of his interest were offered. AD R reported R14 used to come to activities more often when his room was closer to the activities room. Review of the facility's December 2025-February 2026 Activities Calendar revealed every Saturday a Pastor visited the facility at 10:30 AM. On Sundays a Bible Reading activity was on the schedule for 10:30 AM. No singing/musical activities offered and refusals to bingo and social hour were documented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to Intake 2806247 in addition to the recertification survey. Based on observation, interview, and record review, the facility failed to prevent accidents and/or maintain an environment that was free from accident hazards for 2 of 4 residents (R2 and R14) reviewed for accidents and/or accident hazards, for the bathrooms in 6 of 9 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER]/21, room [ROOM NUMBER]/24, room [ROOM NUMBER]/29, room [ROOM NUMBER], room [ROOM NUMBER]/33) reviewed for water temperatures, and 1 of 2 shower rooms (West Shower Room) reviewed for accident hazards. Findings include:An Environmental tour of the facility began on 4/01/26 at 12:05 PM with Director of Maintenance (DoM) K. During an observation of the [NAME] Shower Room on 04/01/2026 at 12:20 PM, the bathroom hand sink was noted to be missing the cold-water knob/handle and the water temperature coming out of the faucet was tempted at 130.3 degrees F. The hot water temperature coming out of the shower was 127.1 degrees F. Further observation of [NAME] Shower Room revealed call light switch located on the shower wall was not working. DoM K confirmed the shower call light switch was not activating the call lights located outside the shower room doors. DoM K stated, I will look into it. During the tour, the Resident in room [ROOM NUMBER] stated, Yes, I could come in check her room and water temperature, but the water gets really hot, be careful. The hot water temperature at the hand sink was 129.4 degrees F. Resident Rooms 19 & 21 share a bathroom, the hot water temperature coming out of their hand sink was 126.0 degrees F. Resident Rooms 22 & 24 share a bathroom, the hot water temperature coming out of their hand sink was 126.1 degrees F. Resident in room [ROOM NUMBER] stated, The water gets really hot, I always need to check the temperature before putting my hands in the water to wash them. Resident room [ROOM NUMBER] had a hand sink located in her room. The resident stated the water gets very hot. The hot water temperature coming out of the hand sink was 126.8 degrees F. Resident Rooms 27 & 29 share a bathroom, the hot water temperature coming out of their hand sink was 127.4 degrees F. Resident Rooms 31 & 33 share a bathroom, the hot water temperature coming out of their hand sink was 125.0 degrees F. Resident room [ROOM NUMBER] had hot water coming out of the hand sink at 120.7 degrees F. Observation of the boiler room reflected the temperature valve on the large holding tank was at 134 degrees. The temperature on the Mixing Valve was 130 degrees. DoM K stated he had last checked it on 3/26/26 and the recorded temperature on the log was 120 degrees. DoM K further stated that this was the temperature of the water that went out to the resident rooms. During an interview on 04/01/2026 at 1:26 PM, Regional Director of Operations (RDOO) U stated he understood that there are concerns with hot water temperatures. He revealed that staff are going (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through checking temperatures and educating staff. During an interview on 4/01/2026 at 2:28 PM, DoM K stated, I turned the water down to 110 degrees and ran a bunch of water out of the tank to help bring down the temperature in the lines. DoM K revealed the water temperature is usually consistent with the mixing valve temperature. During an interview on 4/01/2026 at 3:48 PM, RDOO U revealed that they were having a plumber come out to check things over. During an observation and an interview on 3/31/26 at 10:08 AM, R14 was in his room lying in bed and an unsecured oxygen tank was standing alone at the foot of the bed under the window. The Regional Nurse Consultant (RN) A reported the oxygen tank should be secured. R2 A review of R2's Face Sheet, dated 4/1/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R2's Face Sheet revealed they had multiple diagnoses that included reduced mobility, generalized muscle weakness, morbid obesity, depression, and anxiety. A review of R2's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 12/22/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 14 which revealed R2 was cognitively intact. In addition, R2's MDS revealed they had physical impairment in both of their upper extremities (arms), and they were dependent on staff for bath/showers and transfers. A review of R2's Interdisciplinary Team note, dated 3/3/26, revealed, Summary of event: Resident was up in Bariatric shower chair, while adjusting resident shower chair leg broke and resident fell to floor hitting his head on floor. Post fall findings: Nurse assessed resident. No injuries noted at time of fall. Resident sent to ED for eval related to hitting head. A review of R2's Event Report, dated 3/4/26, revealed on 3/3/26 R2 was being transferred to the shower room for a shower. Certified Nursing Assistant (CNA) J was present and R2 fell when the bariatric shower chair leg broke when he was adjusted in the shower chair. R2 hit his head on the floor, but there were not any visible injuries. R2 complained of pain at a 5 of 10. He was transferred to the hospital for an evaluation. A review of R2's weight records revealed on 2/12/26 R2 weighed 419.1 pounds and the day of the incident (3/3/26) R2 weighed 415.4 pounds. During an interview on 04/01/2026 at 2:32 PM, Director of Maintenance (DOM) K stated he does not do preventive maintenance checks on the shower chairs. He stated that the leg of the bariatric shower chair broke, so there would be no way to check it to see if that would happen. DOM K stated the only moveable parts would be the screws that support the armrests and he would not know what to check on equipment that did not really have any moveable parts. DOM K further stated, I'm not even sure if the chair was rated high enough for him. He's over 500 pounds. DOM K stated he did not know what brand the shower chair that broke was so he could not reference the manufacturer's instructions to see what the maximum weight was for the shower chair that broke or call anyone to find out. DOM K stated he believed the broken chair was already disposed of, but he would check and see if it was still at the facility. He stated if it had not been disposed of, he may be able to find a brand name for it (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and reference the manufacturer's website to see what the maximum allowable weight for that chair was. During a second interview on 04/01/2026 at 2:45 PM, DOM K stated he looked and the broken shower chair was already disposed of. He stated he does not know what brand the broken shower chair was and he does not have another one like it at the facility. DOM K stated that the maximum weight allowed for each shower chair was not printed on the chairs themselves. He stated he was going to order another bariatric shower chair and when he receives it he will write somewhere on the chair the maximum allowable weight. During an interview on 04/01/2026 at 3:41 PM, R2 he remembered falling in the shower room on 3/3/26. He stated the aides were going to roll him down the hallway in the shower chair, but the chair did not look like it would easily roll down the hallway with him in it. R2 stated he was told that they could not use the shower bed because he was too big (heavy) for it. He stated they had the shower chair in the shower room, and they brought him in using a mechanical lift. R2 stated when the aides took him into the shower room and he saw the shower chair he was not sure if it would hold his weight. I'm a big guy and that chair looked like it was made out of flimsy, thin PVC piping. He also stated that the chair looked a little small considering I'm a bigger guy. R2 stated when the aides lowered him into the shower chair using the mechanical lift and as one of them was unhooking the sling, the chair collapsed. He stated he did not remember falling. He just remembered one minute being lowered into the chair and the next minute he was on the floor with an aide standing over him. R2 stated they called the fire department and EMS (Emergency Medical Services) to get him off the floor. He stated when they got him onto the EMS stretcher, he could see that the shower chair had splintered into a million pieces. R2 stated it looked like shattered glass on the floor, but it was the PVC material instead of glass. He stated he had been told that the shower chair was over [AGE] years old. R2 stated he did not have any injuries from the fall. During an interview on 04/01/2026 at 4:30 PM, CNA F stated she knew what the weight limit of a shower chair was based on the color of the chair. She stated she did not know the colors and weight limits off hand of each shower chair but there were multiple colors for multiple weights. For example, there was a specific color for chairs that can hold up to 200 pounds, one for 300 pounds, one for 400 pounds, and one for 500 pounds and up. CNA F stated the color scheme for the shower chairs was not the same as the color scheme for mechanical lift slings, but it was based on a similar idea. During an interview on 04/02/2026 at 8:15, Registered Nurse (RN) E stated the shower chairs are color coded based on maximum weight limits. During an observation in the [NAME] Shower Room on 04/02/2026 at 9:00 AM, RN E was shown two shower chairs (one looked like a standard shower chair, and one looked more heavy duty like a bariatric shower chair). RN E stated he could not tell by looking at the shower chairs what their weight limits were. RN E also stated that he would have to look it up the shower chairs on the manufacturer's website(s) to see the amount of weight each shower chair could hold because he normally does not give residents showers. However, he also stated he could not find the manufacturer's name on the shower chairs he looked at so he would need to contact DOM K to ask what brand they were in order to check the manufacturer's website(s). RN E further stated he doubted that an aide would take the time to look up the weight information on a manufacturer's website if they did not know the weight limit of a particular chair. During another observation on 04/02/2026 at 9:15 AM, CNA G stated she does give residents (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers. CNA G was shown the same two shower chairs in the [NAME] Shower Room that RN E was shown. CNA G looked at the two shower chairs and stated she did not know the weight limit for them. She stated the weight limit should be listed on the chair or written on the chair, but it was not.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to have regular hospice visits documented and/or communication for 1 (R36) of one resident reviewed for hospice services. Findings include:Review of a Face Sheet revealed R36 revealed she was receiving hospice services. Review of the Facility Matrix (Centers for Medicare/Medicaid Services (CMS) Form 802) that listed resident names with triggered care areas provided on 3/30/26 revealed R36 was not triggered for hospice services. Review of the Physician Order for R36 dated 1/9/26 revealed: This resident requires hospice services. Nurse: Monday; Aide: Tues/Fri. Review of the Electronic Medical Record (EMR) for R36 revealed no consistent documentation the resident was receiving regular Hospice visits. During an interview and record review on 3/31/26 at 12:27 PM, Licensed Practical Nurse (LPN) D reported hospice staff will give a verbal report when they visit but no formal sign in to show they were there. A hospice binder for R36 was provided with some handwritten visit documentation but did not reflect the weekly visits for R36. LPN D reported she will document in the progress notes in the EMR when Hospice comes to visit but could not speak for everyone else. The last note documented in the binder was on 3/25/26 from a hospice nurse. LPN D reported R36 received a hospice visit on 3/30/26. Review of the progress notes for R36 between 1/9/26 to 3/31/26 revealed some hospice visits were documented by the nurse, but no documentation reflected the hospice staff visiting R36 on 3/30/26. There was no orderly or consistent process for hospice visits documented.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure vaccinations were offered and up to date according to the Centers for Disease Control (CDC) for 5 Residents (R6, R7, R31, R44, and R45) of 5 residents reviewed for vaccinations. Findings include:Review of the Electronic Medical Records (EMR) for R6, R7, R31, R44, and R45 on 3/31/26 revealed they did not have any vaccination information documented and/or any informed consent forms completed.In an interview on 3/31/26 at 8:25 AM, the Regional Nurse Consultant (RN) A verified all 5 residents (R6, R7, R31, R44, and R45) did not have any of their vaccinations entered the EMR and reported all 5 residents were not up to date on all their vaccinations. RN A reported she would look into the online [name of State vaccine registry] that may have some of their vaccinations in the past registered in the system.In a follow-up interview on 3/31/26 at 2:31 PM, RN A reported all vaccinations were to be offered upon admission and confirmed the 5 residents (R6, R7, R31, R44, and R45) were not newer admissions. RN A reported the influenza vaccination was seasonal, and the COVID vaccination is to be offered every 6 months. The facility had an influenza vaccination and COVID vaccination clinic last November or December 2025. RN A reported they just ordered the RSV (Respiratory Syncytial Virus) and her COVID vaccine for R6 this day of this interview and thought R6 received her influenza vaccine at dialysis but did not have a record of it. RN A reported R6 was caught up with her pneumonia vaccines per the [name of State vaccine registry] report. RN A reported R7 refused her COVID vaccine. RN A reported R31 will have vaccines ordered once her antibiotics were finished, and the other residents will get their vaccinations caught up this week. Review of the Infection Control Program policy last reviewed 1/2025 revealed: Prevention of Infection There are several important facets of prevention. These include identifying possible infections or potential complications of existing infections, instituting measures to avoid complications or dissemination, educating staff and ensuring that they adhere to proper techniques and procedures, screening for possible significant pathogens, and immunizing residents and staff to try to prevent illness. Immunization is a form of primary prevention. Influenza vaccine among resident and employees will be encouraged: . pneumococcal vaccine(s) will also be provided following a physician's order. A review of the rates, severity, or outcome of infections among vaccinated and unvaccinated residents will be available ton (sic) help establish the effectiveness of the facility's preventive efforts.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure that equipment was being maintained in proper working order, potentially affecting all residents that use the hot water, and eat food provided by the kitchen.Findings include:During an initial tour of the kitchen on 3/31/26 at 9:05 AM, the following concerns were observed: 1.) Raetone 2 Door Coolers door seals were no longer sealing properly and was maintaining a temperature of 44 F. (3 Degrees above the highest cold holding temperature.)2.) The True 2 Door Cooler Unit- had torn door seals.3.) Light fixture located inside the hood system did not work and provided no light to staff while they cooked the residents food. Further observation revealed the toggle switch that was used to turn on/off the lights was broken off of/removed from the hood fixture.4.) Observation of the water lines on the Coffee and Juice Machines reflected that they did not have backflow prevention. Further observation of the coffee and juice machines reflected they were not connected to a water filter.During an environmental tour of the facility on 4/1/26 started at 12:05 PM with the Director of Maintenance (DoM) K.During an observation on 04/01/2026 at 12:20 PM, of [NAME] Shower Room it was observed: 1.) The bathroom light was not working. 2.) The cold-water knob/handle on the bathroom sink was missing. 3.) The water temperature coming out faucet was 130.3 F. 4.) The hot water temperature coming out of the shower was 127.1 F. Further observation of W Shower Room revealed call light switch located on the shower wall was not working.DoM K confirmed the shower call light switch was not activating the call lights located outside the shower room doors. DoM K stated, I will look into it.Observation of the boiler room reflected the temperature valve on the large holding tank was at 134 degrees. The temperature on the Mixing Valve was 130 degrees. DoM K that he had last checked it on 3/26/26 and the recorded temperature on the log was 120 degrees. DoM K stated that this was the temperature of the water that went out to the resident rooms.During an interview on 4/01/2026 at 2:28 PM, DoM K stated, I turned the water down to 110 and ran a bunch of water out of the tank to help bring down the temperature in the lines. DoM K revealed the water temperature is usually consistent with the mixing valve temperature. Review of the [NAME] Boiler at Mixing Valve reflected weekly temperature monitoring log from January 5 -through March 26 where the water temperature was at or under 123 degrees prior to going out to resident rooms.During an interview on 4/01/2026 at 3:48 PM, RDOO U revealed that they were having a plumber come out to check things over.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit and ensure an accurate and timely Minimum Data Set (MDS) for 1 Resident (R11) of 4 residents reviewed for Resident Assessments.Findings: R11A review of R11's Face Sheet, dated [DATE], revealed the resident admitted to the facility on [DATE] and expired on [DATE]. R11's Face Sheet revealed they had multiple diagnoses that included Alzheimer's disease, anxiety disorder, spinal stenosis, Chronic Obstructive Pulmonary Disease and Squamous Cell Carcinoma on skin of scalp and neck. Review of R11's progress notes revealed he expired on [DATE]. During an interview on [DATE] at 12:25 PM, MDS Coordinator P revealed they had not completed a Discharge MDS for this resident and the last MDS completed was his admission MDS on [DATE]. During an interview on [DATE] at 12:33 PM, Regional Nurse A revealed that [Name of MDS Coordinator] was unsure of the MDS procedure for discharge/death of a resident. Regional Nurse A stated she was now aware that R11 had not been discharged and stated she would have someone help/assist MDS Coordinator P with the process.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to address Pre-admission Screening/Annual Resident Review (PASARR) in a timely manner for 1 Resident (R35) out of 17 reviewed.Findings include:Review of Social Service Policy & Procedure for Pre-admission admission PROCESS reviewed Date 01/25, revealed, Social Services we'll review each potential resident's Sycho social and behavioral needs and Pre-admission Assessment and Annual Resident Review (PASARR) as available from the referral Source prior to determining appropriateness of placement. Procedure: . 2. Social Services will ensure that the referring party obtains a Level 2 PASARR screening, when indicated. 3. Social services will determine the needed facility services and programs to meet the potential resident's psychosocial and behavioral needs based upon pre-admission assessment and PASARR information.Review of facilities form CMS-802 Matrix for Providers failed to reflect residents that required a PASARR Level II.R35Review of R35's Electronic Medical Record (EMR) on 3/31/26 at 9:34 AM revealed PASARR Level I was completed on 2/19/26 with diagnosis that included: Traumatic Brain Injury and bipolar disorder. Further review of the record failed to reflect Level II PASARR had been completed.Review of R35's EMR revealed the previous year's Level I Change of Condition PASARR was completed on 12/27/24. Further review of R35's EMR failed to reflect Level II had been completed in 2025.During an interview 03/31/2026 at 3:25 PM, Social Services (SS) T revealed she had just started in January and did not have OBRA access. SS T then stated, There is a Level I in (Name of R35's) record. SS T further stated, No, a Level II had not been requested/ completed but I will get back to you (this surveyor) if one was required for him (R35)On 4/1/26 at approximately 8:30 AM, the facility provided documentation that reflected, (Name of R35) had an OBRA Level II Evaluation dated February 07, 2025. Review of Level II Evaluation reflected if Individual remains in the nursing facility a Level II Evaluation is needed by February 06, 2026. The document was not observed in R35's EMR.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide daily care for one (R14) of one resident reviewed for cares of a dependent resident. Findings include:Review of a Face Sheet revealed R14 originally admitted to the facility on [DATE] and had pertinent diagnoses of hemiplegia and hemiparesis (one-sided weakness), vascular dementia, and blindness in right eye. Review of the Care Plan revealed R14 is severely cognitively impaired. During an observation on 3/30/26 at 9:49 AM, R14 was lying in bed, and his hands appeared to be contracted. Hand splints were observed sitting across the room on a table. In an interview on 3/30/26 at 12:31 PM, the Guardian of R14 reported concerns of not having a care conference in a long time to review R14's care. The Guardian reported concerns of R14 not being provided oral care. The Guardian reported she had concerns of R14 being in bed all day and not attending activities. R14 liked religious activities like singing gospel songs and church activities. During an observation on 3/31/26 at 9:16 AM, R14 was observed sleeping in bed and no oral swabs were observed in the room. R14's left eye had a white discharge that was noticeable. Hand splints were observed on the bedside table. During an observation on 3/31/26 at 10:09 AM, R14 was lying in bed, and his left eye had a whitish discharge observed. During an observation on 3/31/26 at 11:40 AM, R14 was still in bed, and no oral swabs were observed in the room. R14 was friendly and talked but did not understand questions regarding his care. R14 had a white discharge in his left eye that was more obvious when he opened his eye. Hand splints were not placed on his hands. During an observation on 3/31/26 at 1:07 PM, R14 was still in bed, and no oral swabs were observed in the room. During an observation and an interview on 3/31/26 at 1:35 PM Certified Nursing Assistant (CNA) G reported she changed R14's brief right before lunch. When questioned about staff not observed in his room during that time frame, CNA G reported she entered his room through the joined bathroom from the room next door. At this time CNA G was asked to check R14's brief and it was saturated. CNA G reported R14 was to be checked and changed every 2 hours. When questioned about R14's oral care, CNA G reported they are to use glycerin swabs to swab his mouth and confirmed there were no oral glycerin swabs readily accessible in his room. CNA G reported she did not provide oral care this day. R14's toenails were very long and wrapped around the tip of his toes. CNA G confirmed there was a discharge in R14's left eye and reported it had been that way for a couple of weeks. CNA G reported she did clean his eyes this day and reported she told the nurse about the discharge. CNA G reported R14 only gets out of bed on Wednesdays and Saturdays. In an interview on 3/31/26 at approximately 4:00 PM, Registered Nurse (RN) reported that R14 does not like to get out of bed and is scheduled to be out of bed on Mondays, Wednesdays, and Fridays. RN Q reported R14 has normal saline eye drops for his eyes to treat his eyes. When questioned about the white discharge from R14's left eye, RN Q reported that is why he gets the eye drops. Review of the Care Plan for R14 revealed: -Urinary Incontinence [related to] severe cognitive impairment, dependent for all ADLs (activities of daily living) and mobility. 1/15/24- Incontinent of bowel and bladder and is a check and change. -Enhanced Barrier Precautions 6/10/24- (R14) has a visual deficit d/t (due to) blindness in the left eye. Wash eyes and face daily. (R14) tends to be passive or refuse group activities. If he is up in his Broda chair he is more likely to come down to an activity, but he does not always like getting out of bed. Staff will encourage (R14) to get up in his chair daily but will respect his wishes if he chooses to stay in bed to watch TV channel . This is not in the Approach section of the care plan.- ADL Functional Status 7/2/24- Goal- . will be clean/well-groomed daily and will participate in cares to his fullest ability. On 7/17/25 an Approach regarding palm protectors: Bilateral palm protectors on in AM and off in PM. Approach: Staff assist and encourage to get up in the broda chair daily. Approach: Use toothettes BID (twice a day)-Evaluation notes at the end of the care plan- Encourage res to get up daily out of bed.-No care plan indicating R14 gets out of bed on any specific days of the week. In an interview on 4/1/26 at 2:39 PM, the Director of Nursing (DON) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported he talked to the nurse the day before about R14's discharge in his eye and put a communication note in the physician's book. The DON reported he did not see any discharge in R14's eye this morning and suggested that maybe the CNA did not clean his eyes per the care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen tubing was dated for 1 (R20) and the oxygen concentrator filter was clean for 1 (R14), of 2 residents reviewed for respiratory devices.Findings include: R20 A review of R20's Face Sheet, dated 3/31/26, revealed resident admitted to the facility on [DATE] with diagnosis that included Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, and Interstitial Pulmonary Disease. An observation on 03/30/2026 at 10:19 AM, revealed R20 was receiving 4.5 L of oxygen via nasal canula. The oxygen tubing was observed to be undated. An observation on 3/31/2026 at 08:26, revealed R20 was in her wheelchair receiving oxygen via nasal cannula. The oxygen tubing was observed to be undated. Review of physician orders reflected, Oxygen tubing to be changed weekly and dated. Clean oxygen filter weekly. Once A Day on Sun 01/02/2024 - Open Ended. During an interview on 03/31/2026 at 11:51 AM, Regional Nurse A stated, Oxygen tubing was supposed to be changed and dated weekly. Review of a Face Sheet revealed R14 originally admitted to the facility on [DATE] and had pertinent diagnoses of hemiplegia and hemiparesis (one-sided weakness), vascular dementia, and blindness in right eye. Review of the Physician Orders dated 1/16/24 for R14 revealed an order for 2 liters of oxygen via nasal cannula for comfort and oxygen saturations below 88%. During an observation on 3/30/26 at 9:49 AM, the oxygen concentrator in R14's room had a filter on the side that was densely dusty and R14 was receiving oxygen via nasal cannula. During an observation and an interview on 4/2/26 at 9:14 AM, Licensed Practical Nurse (LPN) P verified the filter looked dirty. LPN P then cleaned the filter and the plastic holder that was dusty and placed it back on the concentrator.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to timely notify necessary parties, provide support and follow-up for 1 Resident (R27) out of 3 Residents having a psychosocial adjustment difficulty causing delay in care, services and the potential for further psychosocial, mental, and potential physical harm. Findings include:R27A review of R27's Face Sheet, dated 4/1/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. R27's Face Sheet further revealed they had multiple diagnoses that included chronic diastolic (congestive) heart failure, macular degeneration, paroxysmal atrial fibrillation, muscle weakness, need for assistance with personal care and chronic kidney disease.A review of R27's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 2/19/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 14 which revealed R27 was cognitively intact.Review of R27's progress note dated 2/19/26 at 12:00 PM (written by Social [NAME] (SS) T on 2/22/2026 at 11:07 AM) revealed, During resident care conference, resident and resident's son expressed that resident would be interested and talking with a counselor. Social worker completed a referral to BCS on resident to have an evaluation completed. Referral was faxed over and sent via email. Social work to follow up with resident and BCS once they reach out to schedule an evaluation date.Review of R27's Care Plan last reviewed/revised on 2/20/26 failed to reflect any psychosocial concerns/interventions.Review of progress note dated 03/13/2026 at 01:30 PM [Recorded as Late Entry on 03/13/2026 05:16 PM by (Name of Licensed Practical Nurse (LPN) V)] reflected, Entered resident's room to ask why she refused lunch and if she wanted something different to eat. Resident explained how upset she was over not being on the list to see the mobile service unit. Resident stated I have to get out of here one way or another. Not eating or drinking should only take a couple days. I asked if she wanted some music on, listen to a book, or watch TV. Resident replied, no I just want to be in here alone. I had offered prior to lunch to clip resident's toenails and she declined. I reported resident's suicidal ideations with a plan to social work.Further review of residents EMR as of 4/01/26 at 10:20 AM, failed to reflect any documentation/follow-up regarding R27's suicidal ideation.Review of R27's Electronic Medical Record (EMR) on 4/1/26 failed to reflect resident was evaluated/seen by BCS.During an interview on 04/01/2026 at 10:25 AM, concerns were brought to NHA's attention about (Name of R27's) progress notes about wanting to see a counselor, and concern with the suicidal ideation progress note and no follow-up documented in her EMR. During the interview with NHA, SS T walked up and stated she had BSC come out for an initial screen. SS T was asked for a copy of the document because there was no documentation found in the resident's record. SS T stated, Resident was seen and they just need to scan it in the record.During an interview on 4/01/26 at 10:40 AM, SS T stated the resident was seen by BCS on 3/13/26.Review of R27's EMR reflected, the last time she saw the physician was on 3/09/27.Further review of R27's EMR failed to reflect any correspondence/follow-up regarding R27's thoughts of suicidal ideation on 3/13/26 with R27's family, physician, Social Services, DON, and NHA.During an interview on 4/1/26 at approximately 2:30PM, R27 was asked what happened on 3/13/26. R27 stated, Everything happened that day. I truly felt like I could just die that day. I felt depressed, because of the lack of help, it just felt like nobody cared. I felt like giving up. I was upset because nobody had cut my toes nails, then the podiatrist came in and I wanted them to see me, but I was told they wouldn't because I was not on the list. However, I was so upset the old DON did them for me. R27 revealed she had not seen any doctor since then. When this surveyor asked, did any staff from here come in and talk to you about those feelings you were having, R27 stated, NO. I was just very depressed, but I don't feel that way now. R27 further revealed that, No, the social services lady did not come in and follow-up with (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	me. Resident reflected that she doesn't feel like that anymore, but she is still trying to adjust to being here.On 4/1/26 PM at approximately 4:00 PM, SS T and NHA stated she had talked to (Name of R27) a little bit ago and reported the resident feels fine, safe with no concerns. This surveyor stated part of the concern was that this was not followed up on prior to bringing it to their attention. It was revealed to NHA AND SS T that R27 stated to this surveyor that she was depressed and had suicidal thoughts and feelings on 3/13.During an interview on 4/02/2026 at 8:03 AM, Physician W was asked if a resident was having suicidal ideation what would you expect? Physician W stated, I would expect staff to at least call me or call my service and report the concern. Physician W revealed he had not been notified of R27's concern but would follow-up on it.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly label medications in 1 of 1 medication carts inspected (West Medication Cart). Findings include: During an observation on 03/20/26 at 2:29 PM, the medication cart was inspected with Licensed Practical Nurse (LPN) S. The following observations and interviews were made: - An albuterol sulfate HFA box had 37D (a room number) written on it. However, the box and the inhaler did not have any pharmacy labels (they had been torn off) or identifying information that would indicate who the inhaler belonged to if it should become separated from the box and/or an open/discard date on the inhaler. LPN S stated she did not know who the inhaler belonged to (whether it was the resident in room [ROOM NUMBER]D or a resident that had previously been in that room). - A fluticasone propionate 50 mcg nasal spray had 16 (a room number) written on the box. However, the box and the nasal spray did not have any pharmacy labels or identifying information that would indicate who the nasal spray belonged to if it should become separated from the box and/or an open/discard date on the spray bottle. LPN S stated she did not know who the nasal spray belonged to (whether it was the resident in room [ROOM NUMBER] or a resident that had previously been in that room). - LPN S stated the individual vials/diskus/inhalers should be labeled with the resident's name and open/discard by date. She also stated that the boxes should have a pharmacy label on them to indicate who the medication was for. On 03/31/2026 at 11:00 AM, the facility's policy on labeling of medications in medication carts was requested from Regional Nurse (RN) A. On 03/31/2026 at 12:55 PM, the facility provided a copy of their Storage and Expiration Dating of Medications and Biologicals policy and procedure. However, the policy and procedure they provided did not address any labeling besides labeling the medications with open dates and discard dates. The policy and procedure did not address labeling medications, or ensuring medications are labeled, with individual resident names and/or any other identifying information. During an interview on 04/01/2026 at 3:00 PM, Nursing Home Administrator- Support Administrator (NHA-SA) B was informed that the facility sent me a copy of their labeling of medications which only addressed expiration and open/discard dates. She stated they had a general Pharmacy Policy and Procedure that including labeling of medications with resident names. A copy of that policy was requested from NHA-SA B. As of the completion of the survey and exit from the facility, the facility failed to provide a policy that addressed labeling of medications with anything besides open/ discard dates. A review of the facility's Storage and Expiration Dating of Medications and Biologicals policy and procedure, last revised 6/30/25, revealed, 11. Once any medication or biological is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened . Review of the FDA medication insert for Trelegy Ellipta reflected, TRELEGY ELLIPTA should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard TRELEGY ELLIPTA 6 weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first. The inhaler is not reusable. Do not attempt to take the inhaler apart.(https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/209482s003lbl.pdf)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 of 17 sampled residents (R9). Findings include: A review of R9's Face Sheet, dated [DATE], revealed R9 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R9's Face Sheet revealed they had multiple diagnoses that included bipolar disorder, mild cognitive impairment, cognitive communication deficit, obsessive-compulsive disorder (OCD), depression, and dementia with psychotic disturbance. A review of R9's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 4 which revealed R9 was severely cognitively impaired. A review of R9's electronic medical record (EMR), dated [DATE] to [DATE], revealed R9 had Letters of Guardianship (a court document appointing a guardian to a resident who is unable to make medical decisions) that expired on [DATE]. A further review of R9's EMR failed to reveal any currently active Letters of Guardianship and/or any other documentation that R9's guardianship was going to be addressed after [DATE] (e.g., a pending court date). During an interview on [DATE] at 9:50 AM, Social Services (SS) T stated she was new and she was not aware that Resident #9's guardianship papers had expired. She stated she had been a social worker at the facility since [DATE] (approximately 3 months prior to the interview). She stated she would contact R9's guardian and see if they have current Letters of Guardianship or a court date to re-address guardianship. During an interview on [DATE] at 10:00 AM, the Nursing Home Administrator (NHA) stated that her and SS T met with R9's guardian last week. She stated the guardian had stated she was going to continue to be the guardian. The surveyor requested any additional information that the NHA would like to provide showing that R9's guardian was going through the process of updating the guardianship papers (e.g., court date for a guardianship hearing, new Letters of Guardianship). During an interview on [DATE] at 10:10 AM, Regional Director of Operations (RDO) U stated the facility just contacted R9's guardian and she was sending them the paperwork for guardianship. On [DATE] at 5:08 PM, the facility submitted R9's Letters of Guardianship, dated [DATE], that expire on [DATE]. A second review of R9's EMR on [DATE] at 9:10 AM failed to reveal that the facility had scanned R9's current Letters of Guardianship, dated [DATE], into their EMR. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on [DATE]).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235549	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Park Nursing and Rehabilitation Communit	1300 West Broadway Avenue Muskegon, MI 49441

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility failed to post complete and accurate Daily Staffing sheets for 3 of 30 sheets reviewed (3/3/26, 3/7/26, and 3/22/26). Findings include: A review of the Daily Staffing sheets dated 3/1/26 to 3/30/26, revealed the following: - No actual RN (Registered Nurse) hours for 3/3/26 (one RN listed but no hours worked). - No RN coverage for 3/7/26 and 3/22/26. During an interview on 04/02/2026 at 10:30 AM, the Nursing Home Administrator (NHA) stated that she did not know why the Daily Staffing sheets for 3/7/26 and 3/22/26 did not include RN hours. She stated her Payroll Based Journal (PBJ) Staffing Data Report showed she had RN coverage for those days. The NHA stated that the staffing sheets are the ones that they start the days with and if there was a change to the staffing sheets, it should be reflected on it. The NHA stated she did not know why the staffing sheets were not changed to reflect RN coverage. In addition, the NHA was notified that the Daily Staffing Sheet for 3/3/26 had one RN listed on it for 3rd shift, but no hours worked. A copy of the time sheets for the nurses that worked on 3/3/26, 3/7/26, and 3/22/26 were requested from the NHA. The NHA verbally confirmed the request. On 04/02/26 at 12:36 PM, the facility provided the survey team with the Punch Detail- Report for the RN that worked 3rd shift on 3/3/26, 2nd shift on 3/7/26, and 2nd shift on 3/22/26. These reports revealed that the facility had RN an RN that worked 9.18 hours on 3rd shift 3/3/26 and RN coverage on 3/7/26 and 3/22/26 that was not originally recorded on the Daily Staffing sheets for those dates and shifts (the facility modified them between 3/31/26 when copies were originally received and 4/2/26 when the Punch Detail-Reports were received with copies of the modified Daily Staffing sheets).