STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235551	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree of Hubbell Rehabilitation and Health	52225 B Avenue Hubbell, MI 49934

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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 0887 Level of Harm - Actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer covid vaccinations for six Residents (#49, #7, #14, #28, #43, and #45) of nine residents reviewed for covid vaccinations. This deficient practice resulted in death for Resident #49 (R49) from Covid-19 after the facility failed to administer the Covid-19 vaccine as requested.Findings include:Resident #49 (R49) Review of progress notes revealed the following: [DATE] at 2:57 a.m., read in part [R49] observed to be lethargic and not of one self from CNA (Certified Nurse Aide). Vitals revealed 80/49 (blood pressure) p (pulse) 61R (respirations) 18. [DATE] at 5:05 p.m., Patient is covid positive. Currently in isolation with precautions.Has s/s (signs and symptoms) and c/o (complained of) pain, body aches, and cough and congestion. [DATE] at 6:47 p.m., read in part Nurse entered into residents room for medication administration. Found [R49] in [recliner] sitting up right. [Resident] was found unresponsive in chair and did not wake up from sternum rub (a painful stimulus technique used by medical professionals to check if an unconscious or unresponsive person is conscious) CNA and Nurse picked up [resident] and moved to the floor. No pulse was present and not breathing. CNA and nurse started preforming .CPR (cardiopulmonary resuscitation) .EMS (emergency medical service) arrived and declared resident as expired (deceased). R49's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with diagnoses that included Coronary Artery Disease (CAD) [a heart condition caused by plaque buildup in the hearts arteries reducing oxygen to the heart muscle] and Congestive Heart Failure [a condition where the heart muscle is too weak to pump blood efficiently, causing fluid to back up in the lungs, legs and body]. R49 scored a 10 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of moderate cognitive impairment. Progress note dated [DATE] at 3:16 p.m., read in part .call made to [family members name/POA (power of attorney) regarding vaccinations. She [POA] agrees to all vaccinations being given (to R49). Review of a document titled Universal Vaccination Consent Form read in part .Consent for Covid-19 vaccination. I give consent for [facility name] and its staff for me to be vaccinated.signature of resident representative.date [DATE]. (continued on next page)

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

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

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F 0887 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes did not indicate R49 declined the vaccination, that the vaccination was refused by R49, and there was no contraindication for R49 not to receive the vaccination. Review of a policy titled Covid-19 Vaccination date reviewed/revised [DATE], read in part .The residents medical record will include documentation of the following: a. education to the resident or resident representative.b. each dose of the vaccine administered to the resident, or c. if the resident did not receive the Covid-19 vaccine due to medical contraindication or refusal. R49's Michigan Care Improvement Registry (MCIR) [The MCIR provides a comprehensive official record of vaccinations, including dates and types. It highlights which vaccines a person had received, immunization status (up to date or overdue) and identifies vaccines based on age covering from 1994 onwards] dated [DATE], read in part .R49 was overdue for a Covid-19 vaccination.a vaccination was recommended on [DATE]. Review of Death Certificate dated [DATE] read in part .State of Michigan Department of Health and Human Services Certificate of Death.No. 36 Part I. Enter the chain of events-diseases, injuries, or complications that directly caused the death.a. Covid. Resident #14 R14's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with diagnoses that included respiratory failure [a condition where the lungs cannot adequately supply oxygen to the blood or remove carbon dioxide, often causing shortness of breath and fatigue], asthma, Chronic Obstructive Pulmonary Disease (COPD) [a progressive lung disease that causes chronic inflammation, airway narrowing, and damage to the air sacs, leading to severe long-term breathing difficulties] or Chronic Lung Disease. [a progressive disorder that restricts airflow, reducing oxygen intake]. R14 scored a 15 of 15 on the BIMS assessment reflective of intact cognition. Review of a document titled Universal Vaccination Consent Form read in part .Consent for Covid-19 vaccination. I give consent for [facility name] and its staff for me to be vaccinated.signature of resident.date [DATE]. R14's MCIR dated [DATE] read in part .R14 was overdue for a Covid-19 vaccination.the vaccination was recommended [DATE]. Resident #28 (R28) R28's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with diagnoses that included: Coronary Artery Disease (CAD) and hypertension. MDS Section C. cognitive patterns, revealed resident is rarely or never understood and is moderately impaired for making decisions. Review of a document titled Universal Vaccination Consent Form read in part .Consent for Covid-19 vaccination. I give consent for [facility name] and its staff for me to be vaccinated.consent via phone call from resident representative.date [DATE]. R28's MCIR dated [DATE] read in part .R28 was overdue for a Covid-19 vaccination.the vaccination was recommended [DATE]. Resident #43 (R43) (continued on next page)

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F 0887 Level of Harm - Actual harm Residents Affected - Few	R43's MDS dated [DATE], revealed admission to the facility on [DATE] with diagnoses that included: coronary artery disease and hypertension. R43 scored a 15 of 15 on the BIMS assessment reflective of intact cognition. Review of a document titled Universal Vaccination Consent Form read in part .Consent for Covid-19 vaccination. I give consent for [facility name] and its staff for me to be vaccinated.signature of resident.date [DATE]. R43's MCIR dated [DATE] read in part .R43 was overdue for a Covid-19 vaccination.the vaccination was recommended [DATE]. Resident #45 (R45) R45's MDS dated [DATE], revealed admission to the facility on [DATE] with diagnoses that included: diabetes and hypertension. MDS Section C. cognitive patterns, revealed resident is rarely/never understood and never or rarely made decisions. Review of a document titled Universal Vaccination Consent Form read in part .Consent for Covid-19 vaccination. I give consent for [facility name] and its staff for me to be vaccinated.signature of resident representative.date [DATE]. R45's MCIR dated [DATE] read in part .R45 was overdue for a Covid-19 vaccination.the vaccination was recommended [DATE]. During an interview on [DATE] at 2:32 p.m., the Director of Nursing (DON) reported the universal consent for the immunizations was offered upon admission, annually for the residents who reside at the facility, and when the recommendations for the vaccines were amended. If the resident/responsible party signed the consent and agreed to any vaccination, the DON would review the MCIR and the vaccinations would be ordered from the pharmacy. Vaccines had arrived at the facility in two days from when the vaccine was ordered. The resident could receive the vaccine in three days During an interview on [DATE] at 3:23 p.m., Director of Nursing (DON) reported, I did not recognize immunizations were not being completed after consents were signed.we found that at the end of February of 2026 the immunizations were not being given. During an interview on [DATE] at approximately 3:30 p.m., the Assistant Director of Nursing (ADON)/Infection Preventionist reported, I realized I was not keeping track of the immunizations or consents that were signed for the residents who wanted to receive vaccinations at the end of last month. Review of policy titled Covid-19 Vaccination date reviewed/revised [DATE], read in part .It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from Covid-19 by.offering our residents.the Covid-19 vaccine.Covid-19 vaccinations will be offered to residents.as per CDC (Centers for Disease Control).guidelines.Covid-19 vaccinations for residents may be administered in accordance with physician approved standing orders.Residents or their representative and staff will sign the consent form prior to administration of the Covid-19 vaccine.administration of the Covid-19 vaccination should not be delayed. (continued on next page)

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F 0887 Level of Harm - Actual harm Residents Affected - Few	Resident #7 (R7) Review of an admission Record revealed R7 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: chronic obstructive pulmonary disease (COPD). Review of a Minimum Data Set (MDS) assessment for R7 dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 6/15 indicating R7 was cognitively impaired. The immunization record documentation for R7 revealed their Covid-19 vaccination consent was signed via verbal consent by Responsible Party on [DATE] and the Electronic Medical Record (EMR) for R7 had no documentation of the Covid-19 vaccination being administered. Review of R7's current MICR (M-Care Improvement Registry (MICR-State Agency-Immunization Record) R7's read in part SARS-CoV-2 (Covid-19) read in part: Overdue [DATE]. Review of R7's Electronic Medical Record (EMR) read in part: General Progress Note [DATE] 23:53 . (R7) returned from the ED at 2030 via ambulance. Diagnosis: Collapse of lung tissue, heart failure and pneumonia. Review of R7's (EMR) progress notes read in part: [DATE] 13:00 General Progress.Called MD (Medical Doctor) about Sp02 (oxygen saturation level) at 88% on 2L of oxygen.MD agreed to send (R7) to ER (emergency room) for further evaluation. Review of R7's (EMR) read in part: General Progress Note [DATE] 09:54 . (Registered Nurse) RN entered Resident's room to give resident morning medications. Resident was sitting up in bed. RN called out Resident's name. Resident was slow to respond. Residents had a low O2 (oxygen) of 87%. RN initiated standing order of O2 2 liters/per minute. MD (Medical Doctor) notified. ADON (Assistant Director of Nursing) notified. In an interview on [DATE] at 4:10 PM., Assistant Director of Nursing (ADON) A reported she was unsure why R7 had not received his Covid-19 or Pneumococcal immunizations despite having consent for both vaccinations in [DATE] and R7 being at high risk for both viruses. ADON A reported she, the current Director of Nursing DON had noticed this a few weeks ago and began looking into it. ADON A reported R7 was recently sent to the hospital ([DATE]) and came back with a diagnosis of pneumonia, a collapsed lung and heart failure.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure adequate staffing to promote the highest practicable level of physical, mental and psychosocial well-being with the potential to affect all 44 residents that reside in the facility.Findings include:Review of Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (quarterly submissions to CMS by nursing homes to report direct care staffing) for FY [fiscal year] Quarter 4 2025 (July 1 - September 30), read in part . [name of facility] triggered for excessively low weekend staffing.During an interview and record review on 3/3/26 at 1:15 p.m., Chief Operating Officer (COO) G reviewed the weekend schedules and payroll information which revealed low weekend staffing for Certified Nurse Aides (CNA) on the following dates and shifts:Saturday, August 2, 2025 3 CNAs day shift 3 CNAs afternoon shiftSaturday, August 9, 2025 3.5 CNAs day shift 3.5 CNAs afternoon shiftSaturday, September 6, 2025 3 CNAs day shiftCOO G acknowledged the facility had low weekend staffing on the above dates and shifts according to the Facility Assessment [(FA) An annual, documented, facility wide evaluation ensuring resources, staffing, and safety measures meet resident needs].Review of CMS final rule, effective August 8, 2024, mandates that nursing home facility assessments must directly inform and determine staffing requirements.Review of document titled Facility Assessment last updated 2/1/25, read in part .Certified Nurse Aides.minimum of 4-5 CNAs on day shift, Minimum of 4 CNAs on afternoon shift.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review for five out of five Certified Nurse's Aides (CNA's) at least every 12 months. This deficient practice resulted in the potential for inadequate care and unmet resident care needs for all 44 residents residing in the facility.Review of facility personnel records demonstrated the following:CNA E was hired on 11/10/21with no performance reviewCNA K was hired on 11/10/23 with no performance reviewCNA L was hired on 1/15/24 with no performance reviewCNA M was hired on 7/13/23 with no performance reviewCNA N was hired on 2/24/23 with no performance reviewDuring an interview on 3/3/26 at 8:34 a.m., Business Office Manager (BOM) reported I do not have any evaluations of any of the five staff members they are supposed to be done annually.The staff are supposed to have annual performance reviews.During an interview on 3/3/26 at 8:44 a.m., Director of Nursing (DON) acknowledged annual performance reviews were not completed.A request for a policy regarding performance reviews was not provided by the facility prior to exit from the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. This citation pertains to Intake# 2631101.Based on observation, interview and record review the facility failed to fully implement its policy for delivery and storage of controlled medications for one Resident (#51) of three residents reviewed for medication administration, storage and labeling resulting in the misappropriation of 120 narcotic pain medications for R51, the potential for an increase in drug diversion, misappropriation of medications, residents missing pain medication, and the potential for uncontrolled pain and discomfort.Findings include:Review of the Food and Drug Administration current labeling information https://www.fda.gov/drugsatfda read in part: NORCO contains hydrocodone, a Schedule II controlled substance.NORCO-Storage and Disposal-Because of the risks associated with accidental ingestion, misuse, and abuse, advise patients to store NORCO securely, out of sight and reach of children, and in a location not accessible by others, including visitors to the home [see WARNINGS, DRUG ABUSE AND DEPENDENCE]. Inform patients that leaving NORCO unsecured can pose a deadly risk to others in the home . Resident #51 (R51)Review of the admission Record for R51 revealed an original admission to the facility on 8/6/2024 with pertinent diagnoses which included: colon cancer. Review of a Minimum Data Set (MDS) assessment for R51 dated 10/24/2025 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 indicating R51 was cognitively severely impaired.Review of a Physician's Order Summary read in part: (R51) Hydrocodone-Acetaminophen Oral Tablet 10-325MG (Hydrocodone-Acetaminophen) give 1 tablet three times daily.Review of a Facility Reported Incident (FRI) investigation presented to the State Agency (SA) read in part: Date/Time Incident Discovered: 9/19/2025 10:10AM Incident Summary: On the morning of September 19, 2025, during the routine medication pass, it was discovered that a narcotic was missing. The attending nurse contacted Pharmacy to inquire about retrieving the medication from our StatSafe (securely locked medication storage safe), as it was scheduled to be administered. The pharmacy advised that our facility should already have an adequate supply of the medication on hand. Physician notified and Investigation initiated. Investigation Summary/Actions Taken: Facility Reported Incident Investigation Incident Information Date of Incident: September 19, 2025, Resident Involved: (R51) Medication Involved: Hydrocodone 10-325mg (scheduled narcotic pain medication) Investigating Staff: (Previous) Registered Nurse (RN)/Director of Nursing (DON). Summary of Incident. On September 19, 2025, (Previous staff) notified DON that she had contacted the pharmacy to refill (R51's) Hydrocodone 10-325mg. The pharmacy indicated that the resident should have 120 tablets at the facility. The DON initiated a search for the medication and reviewed proof-of-use sheets and shift counts. It was determined that the medication was not administered, destroyed, or documented as wasted, and was unaccounted for. Chain of custody was reviewed for the medication in question, and a nurse was identified as potentially being involved in the missing medication. This nurse is no longer employed at the facility as of September 14, 2025. Notifications- Law enforcement was notified on September 19, with reports made to the State Police and subsequently to the County Sheriff's Office. The attending physician and residents responsible party were notified. Physician provided orders and replacement medications were obtained. Investigation Findings: Thirty-four residents were interviewed with no concerns identified related to medication management. All licensed nurses were interviewed and demonstrated understanding of narcotic control procedures. No concerns were raised regarding other nurses or medication management practices. Medication carts were reviewed, and excess or unnecessary narcotics were secured under double lock. Further audits were conducted to identify any other missing medications from residents, and no additional concerns were identified. Corrective Action- Education on narcotic control procedures has been reinforced. Ongoing audits of controlled substances have been implemented. Excess narcotics for hospitalized residents are secured under double lock. Continued monitoring for compliance with facility policy . Conclusion While (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the investigation did not definitively identify the individual responsible for diversion, the primary staff member of concern has separated employment.With the corrective action plan implemented and the separation of the staff members in question, residents are not at risk for further misappropriation.In an interview/observation on 3/02/2026 at 3:30 PM., RN B reported she was employed at the facility during the time (R51's) narcotic medication (Norco 10 mg- quantity 120 tablets) went missing. RN B reported the medication for the facility was delivered via UPS/FedEx. RN B reported resident medications come in a regular cardboard box with packaging tape and could easily be opened. RN B reported 2 nurses must now retrieve the pharmacy box, open it together and check all inventory, place all medications into the appropriate storage areas and then both nurses sign the packaging slip, stapled narcotic medications together and sign off on the narcotic count sheets indicating which nurses signed the medications in once delivered . In an observation/interview/record review on 3/2/2026 at 4:04 PM., with RN B's assistance the facility medication carts, medication storage room, Stat-safe and a pharmacy medication box delivered earlier along with narcotic medication count sheets were reviewed. RN B reported before (R51's) narcotic medications went missing the medication box from the pharmacy was often unattended once delivered and there were times nurses went the front office where packages were delivered and had to look through other boxes belonging to either the facility or residents to locate the box labeled with pharmacy. That nurse would open the box, check the inventory then fill their medication cart with the regular prescription medications. RN B reported when it came time to check in schedule/narcotics the nurse would call over another nurse and both nurses had to sign off on the inventory sheet from the pharmacy which came in the box. When this surveyor observed the pharmacy box in the medication room it was noted to be opened on the top with a pharmacy label, and regular packaging tape on the top portion of the box which was slit open, as well as the bottom of the box which was taped closed. The box contained no paperwork or medications as they had already been checked in for the day.In an interview on 3/3/2026 at 8:42 AM., RN C reported pharmacy medications delivered to the facility arrive via UPS/Fed/Ex. RN C reported a while back the process changed so that a nurse must sign in the pharmacy box as soon as it is delivered and the drivers/delivery person were supposed to wait for a nurse signature to retrieve the box. RN C reported the box was not locked as it was a regular cardboard box, which was taped with packaging tape. RN C reports despite the fact (R51's) narcotic medications went missing, at times the box was still retrieved from the front office amongst other boxes left for either the facility or residents. RN C reported this does not happen often, but it does continue to happen. RN C stated the fact the box could easily be opened and retaped, especially the bottom of the box because I don't know if or who is required to inspect for tampering. RN C reported he believes that most nurses at the facility do their best with the current procedure, it seems that if someone wanted to take medications from the box, it could potentially still be easy to do. RN C reported if that were to happen, it would probably be easier to catch because now 2 nurses not only sign the narcotic medication count sheets, but they are also both must sign the entire inventory sheet which includes all medications the pharmacy put in the box. RN C reported he is unsure why the medications are delivered from the pharmacy were not in a hard case locking tote or something like that with zip ties, or the ties with inventory numbers. RN C stated I think this would be something that would add another measure of safety, I am unsure of how the facility management and pharmacy used would accomplish this because the pharmacy is not local.In an observation/interview on 3/3/2026 at 10:54 AM, a UPS delivery staff (DS) entered the facility with approximately 4-6 packages including small and medium cardboard boxes and delivered them to the front office where the DON was seated. It was noted the UPS/DS had the DON sign a device for the packages. When asked, the UPS/DS stated, for the box with the pharmacy label I am required to ask for a nurse who shows identification then gives their signature when those are delivered UPS/DS reported he was newer to the route and was informed of this requirement when dropping off packages last week. UPS/DS reported there were no special delivery instructions on the pharmacy package from the sender. This surveyor inspected the box (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	which was cardboard, taped with packaging tape, and a pharmacy label. The box did not appear to be locked or tamper proof. DON reported she was not employed at the facility during R51's FRI and Assistant Director of Nursing ADON A would know a little more if this surveyor had any further questions.In an interview on 3/3/26 at 3:50 PM., ADON A reported she was not employed at the facility at the time of R51's FRI investigation, but did start working shortly afterwards and worked on the follow up and auditing, as well as putting new measures in place for the policy and procedures of Medication/Pharmacy services, storage of narcotics to ensure compliance. ADON A reported the policies do not currently address the actual procedure in place or address how the facility currently receives resident medications. ADON A reported she was unsure if there was anything in the facility Policy and Procedures of Pharmacy Services and Medication Storage and Labeling nor is it written anywhere regarding who is responsible for checking in delivered medications and who is responsible for checking the medication box for tampering when it is delivered and signed for.Review of a facility Pharmacy Services Policy with a revision date of 4/1/2025 read in part: Policy- It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. Definitions: Pharmaceutical Services refers to: The process (including documentation, as applicable) of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and/or disposing of all medications, biologicals, chemicals Compliance Guidelines:1. The facility will provide pharmaceutical services to include procedures that assure the accurateacquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.2. The facility will employ or obtain the services of a licensed pharmacist (in accordance with state requirements) who:a. Provides consultation on all aspects of the provision of pharmacy services in the facility.b. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation; andc. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.5. The facility in coordination with the licensed pharmacist will provide for:a. A system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications .b. Prompt identification of loss of or potential diversion of controlled medications; andc. Determination of the extent of loss or potential diversion of controlled medications.Further review of this policy revealed no new update or revision after R51's narcotic medications went missing to indicate any new practice, nor does it show the current procedure of pharmacy delivery methods including current pharmacy couriers.Review of a facility Medication Storage Policy with a revision date of 1/17/2025 read in part: Policy- It is the policy of this facility to ensure all medications housed on our premises will be stored in the medication room or medication carts according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines.2. Narcotics and Controlled Substances: a. Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key. b. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in refrigerator. c. Any discrepancies which cannot be resolved must be reported immediately as follows: i. Notify the DON, charge nurse, or designee and the pharmacy; ii. Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted; iii. The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators. d. Staff may not leave the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree of Hubbell Rehabilitation and Health	52225 B Avenue Hubbell, MI 49934

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	area until discrepancies are resolved or reported as unresolved discrepancies.Further review of this policy revealed no new update or revision after R51's narcotic medications went missing to indicate any new practice, nor does it show the current procedure of pharmacy delivery methods including current pharmacy couriers.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for all 44 residents living in the facility. Findings include: On 3/1/2026 at 1:18 PM, the staff in the dietary department were observed doing tasks following the lunch service. Dietary Staff P was moving throughout the kitchen and was not wearing a restraint for his beard (a beard net).At 1:29 PM on 3/1/26, the Certified Foodservice Manager (CFM) T stated staff with beards should have a beard net in place. Staff P donned a beard restraint.According to the 2022 FDA Food Code section 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.On 3/1/26 at 1:12 PM, the reach-in refrigerators were observed and contained the following:Silk milk without an opened by (OB) date or a use by (UB) dateAn opened and partially empty 2-quart container of tomato juice without an OB date or UB dateA plastic baggie containing what appeared to be a breaded chicken patty. This item was not labeled and was without an OB date or UB date. Dietary Staff S said, Oh, I am taking that home. She explained it was left over from lunch service to the residents.Boost (a nutritional supplement) with a UB date of 2/24.Sandwiches wrapped in plastic with beige colored filling were stored in a pan marked egg salad sand UB 2/28/26. Dietary Staff R stated those are tuna salad, not egg salad (sandwiches). Staff R noted the UB date was yesterday.According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specifiedunder S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, 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. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded,based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use- by date based on FOOD safety .At 1:24 PM on 3/1/26, a bin was observed on the shelving across from the ovens. This bin housed partially used bags of gravy mixes, sauce mixes, and mashed potato flakes. The bottom interior of the bin had white flakes and other bits of food and powdery debris. The bin also contained three charger cords, instructions for use of a blender, and individual servings of peppermint candy. CFM T said, This should not be like this.At 1:30 PM on 3/1/26, the standing mixer was observed. The undercarriage was noted to have a buildup of dried on debris directly above the mixer arm and bowl and could contaminate the food being mixed when in use.According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (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.At 1:39 PM on 3/1/26, the lunch dishes were observed being washed in the dish room. Dietary Staff S was seen scraping partially eaten food from dirty dishes, loading the dirty (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dishes onto dish racks, and moving the racks into the dishwasher. Staff S would then move to the clean side of the dishwasher and without washing her hands, grabbed the clean dishes and stacked them or carried them into the kitchen for use. The CFM T also observed this process and when questioned said, She should be washing her hands between working the dirty and clean sides.According to the 2022 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: . (E) After handling soiled EQUIPMENT or UTENSILS; . and (I) After engaging in other activities that contaminate the hands.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review the facility failed to maintain the outside grounds garbage storage area in a sanitary condition to prevent the harborage and feeding of pests potentially affecting all 44 residents of the facility.Findings include:During a tour of the grounds on 3/1/26 at 1:45 PM, Certified Foodservice Manager (CFM) T, Dietary Staff Q, and this Surveyor walked approximately 100 feet out to the garbage dumpster area. The area contained three mid-sized dumpsters. The first dumpster was filled with full black trash bags. The bags were stacked and were over the rim of the dumpster and as such, the lid could not be employed. The second dumpster, approximately one foot away from the first dumpster, was covered and upon inspection was half full of filled black garbage bags. The third dumpster, approximately one foot away from the second dumpster, was covered and upon inspection contained one filled black garbage bag.According to the 2022 FDA Food Code section 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be a possible source of contamination of food, equipment, and utensils. Storage areas for garbage and refuse containers must be constructed so that they can be thoroughly cleaned in order to avoid creating an attractant or harborage for insects or rodents. In addition, such storage areas must be large enough to accommodate all the containers necessitated by the operation in order to prevent scattering of the garbage and refuse. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to implement and maintain a comprehensive Quality Assurance Performance Improvement (QAPI) program that addressed the full range of services the facility provides. This deficient practice resulted in the potential for quality-of-care concerns for all 44 residents in the facility.Findings include:During an interview on 3/3/26 at 3:23 p.m., the Director of Nursing (DON) reported I oversee QAPI and I am unaware of any Performance Improvement Projects (PIP) we are working on. We are not working on any PIPs for sentinel events. We are not tracking or monitoring anything.We are not documenting on any action plans. QAPI is a program that needs to be worked on, it is a broken system.Review of policy titled 2026 Quality Assurance and Performance Improvement (QAPI) Plan dated 12/7/25, read in part .The QAPI plan of [facility name] is designed to establish and maintain and organized facility wide program that is data-driven and utilizes a proactive approach to improving quality of care and services throughout the facility.Our facility has a performance improvement programs which systematically monitors, analyzes, and improves it performance.our QAPI program focuses on systems an processes.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to establish priorities for its improvement activities, develop and implement action plans, and review or analyze data collected under the Quality Assurance Performance Improvement (QAPI) program. This deficient practice resulted in the potential for quality-of-care concerns for all 44 residents in the facility.Findings include:During an interview on 3/3/26 at 3:23 p.m., the Director of Nursing (DON) reported I oversee QAPI and I am unaware of any Performance Improvement Projects (PIP) we are working on. We are not working on any PIPs for sentinel events. We are not tracking or monitoring anything.We are not documenting on any action plans. QAPI is a program that needs to be worked on, it is a broken system.Review of policy titled 2026 Quality Assurance and Performance Improvement (QAPI) Plan dated 12/7/25, read in part .The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its sauces and implications of change The facility uses a thorough and highly organized structures approach to determine the root cause of identified problems.The committees overall responsibility is to develop and modify the plan, analyze information, and set priorities for PIP. The facility uses performance indicators to monitor a wide range of care processes and outcomes. Findings are reviewed against established benchmarks and/or targets for improvement. It also includes tracking, investigating and monitoring adverse events, to include developing action plans to prevent recurrences.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a homelike environment free from foul odors and soiled environmental surfaces for all residents residing in the facility.Findings include:During initial entrance tour on 3/1/26 at 1:15 PM., it was noted there was a strong odor of urine when entering the facility. A foul smell of urine was noted on both the A & B units, the hallway to the units and throughout the nursing station areas.In an observation on 3/1/26 at 1:53 PM, room [ROOM NUMBER] both privacy curtains were noted to be heavily soiled with brown smudge marks in multiple areas. In an interview on 3/1/26 at 2:00 PM., Houskeeper (Hsk) I indicated the floors in resident rooms and bathrooms are not mopped daily. Hsk I indicated the strong smell of urine was most likely a combination of the floors not being mopped, soiled linen and soiled briefs that have not been taken out of the facility to the garbage and laundry building. Hsk I reported the laundry facility was in the building next door, and on the weekends sometimes the facility is short staffed, so the linens and garbage are not removed promptly. In an observation on 3/1/26 at 2:11 PM., the bathroom for room [ROOM NUMBER] was soiled with a dried build up urine around the toilet seat and the seat fasteners. Dried feces was smeared on the toilet tank, the rim of the toilet seat, and underneath the toilet seat on the tank bowl. The bathroom had a strong odor of urine.In an observation on 3/01/2026 3:48 PM., strong smell of urine noted on the back unit rooms 1-20 and near nurse's station. In an observation on 3/1/26 at 3:52 PM, room [ROOM NUMBER] both privacy curtains were noted to be heavily soiled. room [ROOM NUMBER] had a strong odor of urine when this surveyor toured the room. In an observation on 3/01/2026 3:50 PM., strong smell of urine noted on while this surveyor toured the unit with rooms 21-31. In an observation on 3/01/2026 3:52 PM., it was noted the bathroom for room [ROOM NUMBER] was soiled with a dried build up urine around the base, feces noted dried and smeared on the toilet tank, rim of the toilet seat, and underneath the toilet seat on the tank bowl. The bathroom had a strong odor of urine.In an observation on 3/02/2026 8:30 AM., strong urine smell on both A & B units upon observation of units for resident initial pool continuation.In an observation on 3/02/2026 2:31 PM it was noted on both A & B units a strong smell of urine while conducting environmental inspection. In an observation on 3/03/2026 at 10:00 AM., the bathroom door of room [ROOM NUMBER]-1 was noted to have a large (greater than 12 inch) circle of paint chipped. Review of the State Operations Manual revealed: Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.A homelike environment is not achieved simply through enhancements to the physical environment. It concerns striving for person-centered care that emphasizes individualization, relationships and a psychosocial environment that welcomes each resident and makes her/him comfortable. It is the responsibility of all facility staff to create a homelike environment and promptly address any cleaning needs.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure Certified Nurse Aide (CNA) training of no less than 12 hours per year was completed for five of five CNAs reviewed for nurse aide training hours. Findings include:During an interview on 3/3/26 at 8:00a.m., Business Office Manager (BOM) revealed the annual 12-hour CNA training is based on the CNA hire date. Review of facility document provided by the BOM revealed the following: CNA E hire date 11/10/21 with 0 hours of training since 5/28/24. CNA K hire date of 11/10/23 with 0 hours of training since 11/10/23. CNA L hire date 1/15/24 with 0 hours of training since hire date. CNA M dire date 7/13/23 with 0 hours of training since hire date. CNA N hire date 2/24/23 with 0 hours of training since 11/15/23. During an interview on 3/3/26 at 8:44 a.m., Director of Nursing (DON) acknowledged five staff did not have 12 hours of annual training. Review of policy titled Nurse Aide Training Program date reviewed/revised 6/11/24, read in part .Each nurse aide shall be provided at least 12 hours of in-service training annually, based on his/her employment date.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to Provide notification of transfer information to the hospital for one Resident (#5) of four reviewed for notification of transfer to the hospital Provide written notification of the bed hold policy and notify the local ombudsman upon transfer to the hospital in 4 of 4 Residents (#2, #5, #7, & #21) reviewed for transfer and discharge requirements.Findings include:Resident #2 (R2) Review of an admission Record revealed R2 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: acute respiratory failure. Review of a Minimum Data Set (MDS) assessment for R2 with a reference date of 12/26/25 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated R2 was cognitively impaired. Review of R2's Electronic Medical Record (EMR) read in part: 2/27/2026 22:42 Progress Note Text: Patient admitted to hospital . further review of R2's EMR revealed no Bed Hold policy or documentation of R2 or R2s representative being given a bed hold policy. In an interview on 3/2/2026 at 9:42 AM., Licensed Practical Nurse (LPN) D reported when a resident is transferred out via ambulance the documents that go with them include a face sheet, physicians orders, and current vital signs LPN D stated I am not aware of a bed hold policy, I am not sure if a resident gets the policy when being transferred out to the ED [emergency department]. During an interview on 3/3/26 at 8:51 AM., Registered Nurse (RN) C reported R2 had readmitted to the facility after about a week in the hospital. RN C reported when a resident gets sent out for an emergency transfer to the hospital, the nurse on duty puts a packet of documents together to give to the Emergency Medical Transport(EMT) personnel to give to the ED staff. RN C reported the packet included a face sheet, physicians orders and current vital signs taken before leaving the facility. RN C reported no bed hold was given when R2 transferred out to the ED on 2/27/26. RN C reported he did not know anything about a bed hold policy from the facility. Resident #21 (R21) Review of an admission Record revealed R21 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: type 2 diabetes. Review of a Minimum Data Set (MDS) assessment for R21 with a reference date of 1/29/2026 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated R21 was cognitively intact. Review of R21's EMR progress notes read in part: 2/10/2026 15:06 COMMUNICATION - with Physician was notified via phone.Resident unable to sit or stand without physical assist, leaning to the left and feeling off balance, blurred vision, and pupils not reacting equally. Speech fairly normal. Unable to state the day, month, or year and unable to focus and answer questions appropriately. Restless and complained I feel like I am going to pass out, as EMS arrived at 1445. Physically/manually lifted onto the EMS cot, due to inability to stand on his own. Report to ER, prior to transport. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R21's EMR revealed no bed hold policy documentation for R21's transfer to the hospital on 2/10/26. Resident #7 (R7) Review of an admission Record revealed R7 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: chronic obstructive pulmonary disease (COPD) Review of the MDS assessment for R7 with a reference date of 2/17/2026 revealed a BIMS score of 6/15 which indicated R7 was cognitively impaired. Review of R7's EMR progress notes read in part: 2/25/2026 13:00 General Progress.Called MD (Medical Doctor) about Sp02 (oxygen saturation level) at 88% on 2L of oxygen.MD agreed to send (R7) to ER (emergency room) for further evaluation. Review of R21's EMR revealed no bed hold policy documentation for R7's transfer to the hospital on 2/25/26. Resident #5 (R5) Review of R5's MDS assessment dated [DATE], revealed admission to the facility on 5/22/23. The EMR revealed R5 was discharged from the facility and admitted to the hospital on [DATE] and 10/6/25. Review of the miscellaneous section of the EMR with the Director of Nursing (DON) revealed no evidence of a written notification of transfer and no bed hold policy being provided to the resident/representative. There was no evidence of notification to the Long-Term Care (LTC) Ombudsman provided by the facility. During an interview on 3/3/26 at 7:51 a.m., the DON reviewed the EMR and reported there was no written notification of transfer from the facility to the hospital, and indicated it should be in the EMR under the miscellaneous section. Review of policy titled Bed Hold Policy last reviewed/revised 7/14/25, read in part . The facility will provide the receiving provider [hospital] the following: a. contact information of the practitioner responsible for the care of the resident, b. Resident representative information including contact information, c. Advance Directive information, d. All special instructions or precautions for ongoing care, as appropriate, 3. Comprehensive care plan goals, f. All other necessary information, including a copy of the resident's discharge summary as applicable and any other documentation to ensure a safe and effective transition of care. During an interview on 3/3/26 at 9:15 a.m., Nursing Home Administrator (NHA) designee W reported, I am unable to find the ombudsman list for September or October and I cannot find any information regarding bed holds for the residents who were discharged from the facility and admitted to the hospital. Review of the facility 'Bed Hold' policy with a revision date of 7/14/2025 read in part: Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed -hold policy and addresses information explaining the return of the resident to the next available bed. Definitions: (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Bed-Hold, means holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization. Policy Explanation and Compliance Guidelines: Bed Hold Notice Upon Transfer 1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: a. (State) reimburses a nursing facility to hold a bed for up to ten days during temporary absence from the facility due to admission to the hospital only when the beneficiary leaves the facility. b. There is no limit to the number of hospital leave days per resident that may be billed to Medicaid annually as long as there are no more than 10 consecutive leave days per hospital stay. c. Private Pay residents may be given the option to pay the facility the per diem rate to hold their bed while absent from the facility. d. Residents will return to his or her previous room, if available. If that room is unavailable, the resident entitles to the next bed available in a semi-private room with a roommate of the same sex. Review of policy titled Transfer and Discharge last reviewed/revised 8/7/22, read in part .The Social Services Director or designee, will provide copies of notices for .transfers to the Ombudsman.such as in a list of residents on a monthly basis.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review, the facility failed to ensure residents received diets as prescribed by a physician and in accordance with the plan of care for four Residents (#1, #17, #28 and #34) of five residents reviewed for therapeutic diets. Findings include:Resident #28 (R28)During breakfast meal rounds on 3/2/2026 at 8:05 AM, R28 was noted to have scrambled eggs and sausage with gravy served. R28's meal tray card indicated Diet: 2gm (gram) Na+ (Sodium).During an interview on 3/2/2026 at 8:35 AM, the Certified Food Service Manager (CFM) T was asked about the diet and she stated, We are out of low sodium gravy right now.The medical record for R28 indicated a physician diet order dated 9/4/2025 of No Added Salt (NAS), Low fat. Beneprotein (a protein supplement) BID (twice daily).Resident #17 (R17)During breakfast meal rounds on 3/3/2026 at 8:25 AM, R17 was observed to be eating in the dining room and received a cheese and egg croissant and oatmeal. R17's meal tray card indicated a Diet: 2gm Na+.The medical record for R17 indicated a physician diet order dated 8/11/2025 of No Added Salt (NAS) diet, Regular texture, Thin consistency.Resident #1 (R1)During breakfast meal rounds on 3/3/2026 at 8:30 AM, R1 received a cheese and egg croissant, oatmeal, and mandarin oranges. R1's meal tray card indicated Diet: Renal.The medical record for R1 indicated a physician diet order dated 2/11/2026 of Renal Diet Regular/IDDSI 7 texture, Thin consistency.Resident #34 (R34)The medical record for R34 was also identified with a physician diet order dated 10/20/2025 of Renal diet, Regular/IDDSI (International Dysphagia Diet Standardization Initiative) 7 texture, Thin consistency. This resident also had the potential to be affected by the staff's knowledge gap. During an interview on 3/3/2026 at 3:18 PM, CFM T stated there were differences in the 2-gram sodium diet and an NAS diet. The NAS diet was a regular diet with the only change of adding no additional salt. CFM T stated there were no residents on a 2 gram sodium diet in the facility. She was surprised when she printed the meal tray cards for R28 and R17 from her computer program and the tray cards read 2 gram sodium diet. The renal diets were also discussed. CFM T listed off several foods including mandarin oranges that should not be served to residents on a renal diet. She was unaware that mandarin oranges had been observed on R1's breakfast tray. The planned menu for the renal diet was reviewed and read, Hot cereal renal, scrambled eggs, cranberry orange muffin. This did not match the breakfast R1 had been served, a cheese and egg croissant, oatmeal, and mandarin oranges. CFM T stated that those on a renal diet could have salt. When the renal diet was discussed, CFM T asked this Surveyor, Where did you get that list of foods to be served and foods to be avoided on the renal diet? The answer was given that the list was taken from the facility's diet manual. CFM T stated there had been a list of foods to be avoided on a renal diet in the kitchen but it was not there to assist the staff when serving R1 and R34 who both had renal diets ordered by the physician. When CFM T was asked if her new Consultant Registered Dietitian (RD) had ever been in the building, to assist with the therapeutic diets, CFM T stated the RD had not been to the facility yet. The RD contract had started 1/1/2026 and they had been trying to set up a telehealth system, but it was not yet in place.The Diet Manual for the facility was presented (Long Term Care Diet Manual copyright 2022 Health Technologies, Inc) and Renal Precautions page 163 read in part, .If an individual is on dialysis, it is suggested that the Registered Dietitian or other member of the interdisciplinary team periodically contact the Dialysis Dietitian for co-ordination of care as needed. 7. The Registered Dietitian can provide further and more specific Renal Diet information and guidelines. Consider the following Renal Precautions when making meal selections that will help to manage your sodium, potassium and phosphorus intake. Avoid use of a salt packet and do not add salt at the table. Page 166 titled: Renal Diet Food Choice Lists for Meal Planning. 4. Using salt at the table is discouraged and salt packets are not added to meals sent to individuals that dine in their rooms.

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Greentree of Hubbell Rehabilitation and Health	52225 B Avenue Hubbell, MI 49934

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain consent for psychotropic medications for one Resident (#3) of five residents reviewed for unnecessary medications. Findings include: Resident #3 (R3)Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed admission to the facility on [DATE], with diagnoses including: anxiety disorder, depression, and post traumatic stress disorder [(PTSD) A mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or violent events].Review of R3's Electronic Medical Record (EMR) included active physician orders for the following medications:Chlorpromazine Oral Tablet 50 MG(milligram),Duloxetine Oral Capsule Delayed Release Sprinkle 60 MG- 1 capsule by mouth (psychotropic medication prescribed for depression), and;Mirtazapine Oral Tablet 30 MG Give 1 tablet by mouth at bedtime (psychotropic medication prescribed for depression).The EMR did not reveal any consent signed by the R3 or their responsible party.During an interview on 3/3/26 at 12:20 p.m., The Director of Nursing (DON) reported the consents for psychotropic medications are completed upon admission to the facility by the Social Services Designee (SSD) V. The DON was unable to locate a consent that had been signed by the responsible party in the EMR.During an interview on 3/3/26 at 12:36 a.m., the SSD V acknowledged signed consents were not in the EMR and she could not locate any signed consents not scanned into the EMR, in her office.Review of policy titled Use of Psychotropic Medication last reviewed/revised 7/15/25, read in part .Residents and/or representative shall be educated on the risks and benefits of psychotropic drug use.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on observation, interview, and record review the facility failed to deliver mail/package unopened for one Resident (#20) of one resident reviewed for privacy related to receiving mail.Findings include:Resident #20 (R20)During an interview on 3/1/2026 at 2:28 PM, R20 voiced a concern about not receiving a package on the preceding Friday (2/27/2026). R20 had ordered a product and had been advised by a family member the order had been acknowledged as delivered. R20 stated they did not receive the package and had requested her Certified Nurse Aide (CNA) U look around the building for it. R20 said, I got it Saturday when I asked (CNA U) to look for me. R20 said CNA U found it opened in the conference room. R20 said, It had been opened and left there. I was very mad. I filled out a complaint and reported it to the administrator. The package was in R20's room and was observed to be clearly addressed to R20.During an interview on 3/1/2026 at approximately 2:35 PM, CNA U stated they did find the package on Saturday (2/28/2026) opened and in the conference room and they delivered it to R20.On 3/2/2026 at 3:10 PM, Social Service Designee (Staff V) stated she kept the grievance log and could not find the February log but offered to ask Nursing . Staff V stated she would present it when she found it.During an interview on 3/2/2026 at 4:15 PM, Assistant Director of Nursing (ADON) A stated she was investigating the opened package. ADON A said she knew several packages were delivered on Friday and she had placed the packages in the Business Office for safe keeping.During an interview on 3/2/2026 at 4:27 PM, Business Office Manager (Staff O) stated she had opened the package for R20 in error. Staff O said instead of delivering it to the resident, she put it on the conference room table around 3:00 or 4:00 PM. Staff O did not deliver it to the Resident on Friday.On 3/2/2026 at 4:50 PM, the grievance log was observed to have the concern of Package was opened by staff member for R20.During an interview on 3/2/2026 at approximately 5:00 PM, ADON A stated she was still investigating the concern but had not talked to R20 and did not know who found the package and delivered it to the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide information to formulate an advance directive for two Residents (#3 and #49) of twelve residents reviewed for advance directives.Findings include:Resident #3 (R3)Review of R3's Minimum Data Set (MDS) assessment, dated 2/17/26, revealed admission to the facility on [DATE].Review of R3's Electronic Medical Record (EMR) did not reveal the resident/responsible party had received advance directive information or formulated an advance directive.Resident #49 (R49)Review of R49's MDS assessment, dated 11/18/25, revealed admission to the facility on 5/16/25.Review of R49's EMR did not reveal the resident/responsible party had received advance directive information or formulated an advance directive.During an interview on 3/2/26 at 2:45 p.m., Social Services Designee (SSD) V reported the advance directives had not been completed for these residents and were supposed to be done on admission and reviewed quarterly.Review of policy titled Communication of Code Status last reviewed/revised 2/21/24, read in part (.It is the policy of this facility to adhere to resident rights to formulate advance directives.the facility will follow facility policy regarding a residents right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide timely information of a change in coverage and subsequent changes in the amount billed for services for one Resident (#35) of three residents reviewed for receipt of Notice of Medicare Non-coverage. Findings include:Resident #35 (R35)The facility presented a list of residents whose Medicare Part A Service had ended and were eligible to receive a Notice of Medicare Non-coverage (a document to alert of payment changes). Three residents on this list were chosen, and their medical records were requested to ensure proper notification had been delivered two days prior to a change in billing.On 3/3/2026 at 2:37 PM, during this review, it was determined R35 was notified his Medicare coverage for current PT/OT/ST (Physical Therapy/Occupational Therapy/Speech Therapy) services would end on 10/8/2025. This form instructed the resident how to appeal this decision to end coverage and what would happen next. The signature line indicated R35 was notified that coverage of my services will end on the date on this notice, and that I can appeal this decision by contacting my QIO (Quality Improvement Office). The signature line was marked Verbal consent from DPOA (Durable Power of Attorney) and dated 10/9/25 (the day after change in charges had occurred).During an interview on 3/3/2026 at 2:45 PM, the Business Office Manager (Staff O) stated the form should have been given 48 hours before Medicare coverage ended. Staff O was asked for a policy for Notice of Medicare Non-coverage. The facility presented a policy titled Social Services dated as reviewed/revised on 6/29/2023, which read in part, 4. The social worker, or social service designee, will pursue the provision of any identified need for medically related social services of the resident. p. Notification to resident/responsible party of Notice of Medicare Non-coverage and Beneficiary Notice.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake# 2631101 Based on observation, interview and record review, the facility failed to protect the resident's right to be free from misappropriation of property, by a staff member for one Resident (Resident #51) of three residents reviewed for misappropriation of property, resulting in 120 narcotic medication pills missing, increased potential for undetected controlled drug diversion and the potential for uncontrolled pain and discomfort with medication delivery delays from refill too soon notices flagged by the pharmacy provider.Findings include:Review of the Food and Drug Administration current labeling information https://www.fda.gov/drugsatfda read in part: NORCO. Abuse.NORCO contains hydrocodone, a substance with a high potential for abuse similar to other opioids including fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxycodone, oxymorphone, and tapentadol, can be abused and is subject to misuse, addiction, and criminal diversion .Resident #51 (R51)Review of an admission Record revealed R51 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: colon cancer. Review of a Minimum Data Set (MDS) assessment for R51 with a reference date of 10/24/2025 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 which indicated R51 was cognitively severely impaired.Review of a Physician's Order Summary read in part: (R51) Hydrocodone-Acetaminophen Oral Tablet 10-325MG (Hydrocodone-Acetaminophen) give 1 tablet three times daily.Review of a Facility Reported Incident (FRI) investigation presented to the State Agency (SA) read in part: Date/Time Incident Discovered: 9/19/2025 10:10AM Incident Summary: On the morning of September 19, 2025, during the routine medication pass, it was discovered that a narcotic was missing. The attending nurse contacted Pharmacy to inquire about retrieving the medication from our StatSafe (securely locked medication storage safe), as it was scheduled to be administered. The pharmacy advised that our facility should already have an adequate supply of the medication on hand. Physician notified and Investigation initiated. Investigation Summary/Actions Taken: Facility Reported Incident Investigation Incident Information Date of Incident: September 19, 2025, Resident Involved: (R51) Medication Involved: Hydrocodone 10-325mg (scheduled narcotic pain medication) Investigating Staff: (Previous) Registered Nurse (RN)/Director of Nursing (DON). Summary of Incident. On September 19, 2025, (Previous staff) notified the DON, she had contacted the pharmacy to refill (R51's) Hydrocodone 10-325mg. The pharmacy indicated the resident should have 120 tablets at the facility. The DON initiated a search for the medication, reviewed proof-of-use sheets and reviewed shift counts. It was determined the medication was not administered, destroyed, or documented as wasted, and was unaccounted for. Chain of custody was reviewed for the medication in question, and a nurse was identified as potentially being involved in the missing medication. This nurse is no longer employed at the facility as of September 14, 2025. Notifications-Law enforcement was notified on September 19, with reports made to the State Police and subsequently to the County Sheriff's Office. The attending physician and residents responsible party were notified. Physician provided orders and replacement medications were obtained. Investigation Findings: Thirty-four residents were interviewed with no concerns identified related to medication management. All licensed nurses were interviewed and demonstrated understanding of narcotic control procedures. No concerns were raised regarding other nurses or medication management practices. Medication carts were reviewed, and excess or unnecessary narcotics were secured under double lock. Further audits were conducted to identify any other missing medications from residents, and no additional concerns were identified. Corrective Action- Education on narcotic control procedures has been reinforced. Ongoing audits of controlled substances have been implemented. Excess narcotics for hospitalized residents are secured under double lock. Continued monitoring for compliance with facility policy. Conclusion While the investigation did not definitively identify the individual responsible for diversion, the primary staff member of concern has separated employment.With the corrective action plan implemented and the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	separation of the staff members in question, residents are not at risk for further misappropriation.In an interview on 3/2/2026 at 4:29 PM, at the time (R51's) narcotic medication (Norco 10mg-quanity 120 tablets) went missing, RN B indicated the medication was most likely taken from a staff member when it was delivered. RN B revealed the nurse identified was not signing for the pharmacy medication box when it was delivered and the box was mixed in with other boxes or packages that had been delivered. RN B stated if I remember correctly when the investigation was being completed it was noticed the entire inventory list that has all the medications in the box was missing, along with 4-narcotic count sheets totaling 120 pills and the 4 packages containing 30 pills each In an interview on 3/3/2026 at 8:42 AM., RN C reported at the time R51's narcotic medication went missing it would have been very easy for anyone including staff or a delivery personnel to have tampered with and/or opened the pharmacy medication box. RN C stated, I think it was probably a previous nurse, because most people would not know to take the entire inventory sheet, along with the narcotic count sheets with the narcotic medications that were missing. the box was not locked and was in a regular cardboard box, which was taped with packaging tape RN C reported at times the pharmacy box was still in front office amongst other delivered packages/boxes. RN C stated the fact the box could easily be opened and retaped, especially the bottom of the box because I don't know if or who is required to inspect for tampering. In an observation/interview on 3/03/2026 at 10:54 AM, a UPS delivery staff (DS) entered the facility with approximately 4-6 packages including small and medium cardboard boxes and delivered them to the front office. This surveyor inspected the box which was cardboard, taped with packaging tape, and a pharmacy label. The box did not appear to be locked or tamper proof. DON reported she was not employed at the facility during R51's FRI and Assistant Director of Nursing ADON A would know a little more if this surveyor had any further questions.In an interview on 3/3/26 at 3:50 PM., ADON A reported she was not employed at the facility at the time of R51's FRI investigation, but did start working shortly afterwards and worked on the follow up and auditing, as well as putting new measures in place for the policy and procedures of Medication/Pharmacy services, storage of narcotics to ensure compliance. ADON A reported it was her understanding from the previous DON and Nursing Home Administrator (NHA) working at the time that (R51's) medications along with the inventory list, and narcotic count sheets were taken out of the pharmacy medication box once delivered by a former staff member who previously had issues with substance abuse.Review of a facility Abuse, Neglect and Exploitation policy referenced by the State Operations Manual (SOM)- revision 2025, Appendix PP-F600/F607 read in part: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Further review of this policy did not address or reference the SOM or protocol for misappropriation (F602).

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for psychotropic medications for one Resident (#20) of five residents reviewed for unnecessary medications.Findings include:Resident #20 (R20)A review of R20's electronic medical record (EMR) revealed an admission date of 5/1/2024 with diagnoses which included depression and anxiety disorder. The medical record included active Physician's Orders dated 3/1/22 including: Cymbalta (psychotropic medication prescribed for anxiety) Oral Capsule Delayed Release Particles 60 MG (milligrams) and busPIRone (psychotropic medication prescribed for depression) HCl (hydrochloride) Oral Capsule 10 MG.The Care Plan for R20 included focus plans for antidepressant medications and antianxiety medications.During an interview on 3/2/2026 at 3:40 PM, the Director of Nursing (DON) was asked if the facility had tried a gradual dose reduction (GDR). The DON stated, We rely on our pharmacist to let us know when GDRs are due.The EMR was reviewed and no evidence of a GDR attempt could be found. The facility staff was asked to determine when a GDR had been attempted for the prescribed psychotropic medications for R20.During an interview on 3/3/2026 at 1:50 PM, the DON stated, There is no GDR information for this resident. There are no GDR attempts for her (R20). There is no documentation to reflect the lack of GRDs.The facility policy titled, Use of Psychotropic Medication dated as reviewed/revised 7/15/2025 was reviewed. This policy read in part, 6. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain a PASARR (Preadmission Screening/Annual Resident Review) prior to admission for one Resident #3 (R3) of one resident reviewed for PASARR screening.Findings include:Resident #3 (R3)Review of Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE] with active diagnoses that included: Post Traumatic Stress Disorder (PTSD), anxiety disorder, depression, and Non-Alzheimer's dementia.During an interview on 3/2/26 at 3:33 p.m., Registered Nurse (RN) X reported we complete the PASSAR just prior to admission to the facility and then annually.the only one for R3 was completed on 10/2/24 and not one prior to her admission on [DATE]. R3 does need a new or updated PASSAR.Review of policy titled Resident Assessment-Coordination with PASARR Program date reviewed/revised 8/14/25 read in part .This facility coordinates assessments with the preadmission screening and resident review (PASARR) program.all applicants to this facility will be screened.PASSAR Level 1 initial pre-screening is completed prior to admission.

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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 store oxygen equipment in a sanitary manner for two Residents (#18 and #37) of three residents reviewed for oxygen equipment and storage.Findings include:Resident #18 (R18) Review of R18's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 4/1/24 with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD) [a progressive long term lung disease that causes obstructed airflow, making it hard to breathe] and anxiety disorder. During an observation on 3/2/26 at 7:38 a.m., R18's oxygen tubing was draped over an oxygen concentrator with the nasal cannula laying on the floor. During an interview on 3/2/26 at 8:23 a.m., Registered Nurse (RN) B reported, R18 on not on continuous oxygen but the oxygen cannula and tubing is supposed to be in a bag when not in use, not just lying on the floor. Resident #37 (R37) A review of R37's medical record revealed a most recent admission date of 1/29/2026 with diagnoses which included pulmonary fibrosis (chronic progressive disease where deep lung tissue becomes scarred, severely inhibiting oxygen absorption), COPD (Chronic Obstructive Pulmonary Disease a progressive lung disease that restricts airflow making it difficult to breathe) and chronic respiratory failure (a long term condition where lungs cannot properly oxygenate blood). The active Physician's Orders included: O2 (oxygen) at 1L per NC for sats 90% (to flow at one liter through a nasal cannula if the measured O2 in the blood was less than 90% saturation) dated 2/3/2026 and Change Oxygen Tubing weekly every night shift every Thu (Thursday) of oxygen use dated 1/29/2026. The Minimum Data Set assessment (MDS) dated [DATE] included documentation of oxygen therapy (Section O C1) both on admission' and while a Resident. On 3/1/2026 at 2:49 PM, R37 was observed in bed and wearing a nasal cannula with O2 flowing. The tubing extended from his face to the floor in coils and was connected to an oxygen concentrator and contained no labeling as to what date the tubing had been changed. R37 stated he was not sure, but it had been a while since the tubing had been changed. On 3/3/2026 at 10:01 AM, R37 was observed sleeping with O2. The O2 tubing was dated but long loops of coiled tubing were lying on the floor. The medical chart for R37 contained a care plan with a focus which included COPD with interventions of: Avoid extremes of hot and cold. Date Initiated: 01/30/2026 Give oxygen therapy as ordered by the physician. Date Initiated: 01/30/2026 Head of bed to be elevated . or out of bed upright in a chair during episodes of difficulty breathing (Dyspnea). Date Initiated: 01/30/2026 Monitor for difficulty breathing (Dyspnea) on exertion. Remind me not to push beyond endurance. Date Initiated: 01/30/2026 CNA Monitor for . acute respiratory insufficiency: Anxiety, Confusion, Restlessness, . Date Initiated: 01/30/2026 (continued on next page)

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Greentree of Hubbell Rehabilitation and Health	52225 B Avenue Hubbell, MI 49934

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The oxygen saturation (O2 sats) was reviewed and noted to have been documented beginning on 1/29/26 and were recorded approximately once a day. There was no documentation from 1/31/26 through 2/3/26 or on 2/5/26, or on 2/10/26. During an interview on 3/3/2026 at 11:11 AM, the Director of Nursing (DON) discussed her expectations for O2 use. The DON said, I would not expect the tubing to be on the floor. It needs to be in a proper bag. She stated further the O2 tubing should be changed each week and dated. The DON also stated the O2 sats should be documented for each shift for those residents on O2 and the policy should be followed for care planning O2 use. The facility policy Oxygen Administration dated as reviewed/revised 8/2/25 read in part, Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. e. Keep delivery devices covered and in plastic bag when not in use. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system. b. When to administer, such as continuous or intermittent and /or when to discontinue oxygen use. c. Equipment setting for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring complications associated with the use of oxygen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235551	A. Building B. Wing	03/03/2026

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify triggers or implement a comprehensive person-centered care plan for one Resident #3(R3) of one resident reviewed for Post Traumatic Stress DisorderFindings include:Resident #3 (R3)Review of Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE] with active diagnoses including post traumatic stress disorder [(PTSD) a mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or violent events], anxiety disorder, depression, and Non-Alzheimer's dementia.Review of Electronic Medical Record (EMR) revealed a psychiatric or mental health consult dated 1/8/26, read I part .Psychiatry Follow up.Post Traumatic Stress Disorder.Nonpharmacologic: maintain trauma informed approach, minimize environmental triggers when possible, use calm redirection/distraction, and comfort measures. Continue close observation for agitation/distressDuring an interview on 3/2/26 at 9:20 a.m., Social Services Designee (SSD) V reported I have not communicated with any mental health agency to inquire about R3 to see if she has any triggers or what her past trauma was.I usually interview the resident and implement a care plan or interventions. I have not developed a care plan to address her PTSD, and I have no idea what her triggers might be.During an interview on 3/3/26 at 9:45 a.m., Director of Nursing (DON) acknowledged there is no care plan or interventions regarding PTSD for R3.Review of Facility Assessment (FA) last updated 2/1/25, read in part . [Facility name] accepts and care for residents with the following conditions.Mental health and behavior: Manage the medical conditions and medication related issues cause psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as.PTSD.Review of policy titled Social Services date reviewed/revised 6/29/23, read in part .The facility.will provide medically related social services to each resident to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being.identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident.meeting the needs of residents who are.coping with stressful events.the residents plan of care will reflect any ongoing medically related social service needs and how these needs are being addressed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure two Certified Nurse Aides (CNA's) [L and N] of five CNA's reviewed for competencies had the required yearly competency trainings, including demonstration in skills and techniques necessary to care for residents.Findings include:A review of facility staff personnel records revealed CNA L was hired 1/15/24. CNA L's personnel record did not demonstrate dated competency skills since the date of hire.A review of facility staff personnel records revealed CNA N was hired 2/24/23. CNA N's personnel record did not demonstrate dated competency skills since the date of hire.During an interview on 3/3/26 at 8:34 a.m., Business Office Manager (BOM) O reported two of the CNA's do not have competency trainings in their personnel files and the staff is supposed to have annual competency training.Review of policy titled Competency Evaluation date reviewed/revised 1/1/25, read in part It is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skill for performing their job.evaluating competency of staff is accomplished through the facilities training program.initial competency is evaluated during the orientation process.subsequent or annual competency is evaluated.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to Ensure eligible residents were administered pneumococcal vaccinations after receiving consent for 2 Residents (#7 & #28) of 5 residents reviewed for immunizations/vaccinations and;Have a process for tracking and securely documenting the pneumococcal vaccination status of residents. Findings include: Resident #7 (R7) Review of an admission Record revealed R7 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: chronic obstructive pulmonary disease (COPD) Review of a Minimum Data Set (MDS) assessment for R7 with a reference date of 02/17/2026 revealed a Brief Interview for Mental Status (BIMS) score of 06/15 which indicated R7 was cognitively impaired. Review of R7's Electronic Medical Record (EMR) read in part: General Progress Note 2/25/2026 09:54 Text: (Registered Nurse) RN entered Resident's room to give resident morning medications. Resident was sitting up in bed. RN called out Resident's name. Resident was slow to respond. Residents had a low O2 (oxygen) of 87%. RN initiated standing order of O2 2 liters/per minute. MD (Medical Doctor) notified. ADON (Assistant Director of Nursing) notified. Review of R7's EMR progress notes read in part: 2/25/2026 13:00 General Progress.Called MD about Sp02 (oxygen saturation level) at 88% on 2L of oxygen.MD agreed to send (R7) to ER (emergency room) for further evaluation. Review of R7's EMR read in part: General Progress Note 2/25/2026 23:53 Note Text: Resident returned from the ED at 2030 via ambulance. Diagnosis: Collapse of lung tissue, heart failure and pneumonia. Review of R7's EMR the revealed: The immunization record documentation for Resident#7 revealed their Pneumococcal vaccination consent was signed via verbal consent by Responsible Party on 10/28/2025. R7 had no documentation of the Pneumococcal vaccination being administered. Review of the Center for Disease Control and Prevention (CDC) read in part: Recommended Adult Immunization Schedule for Ages 19 Years or Older UNITED STATES 2025-Previously received both PCV13 and PPSV23 but NO PPSV23 was received at age [AGE] years or older: 1 dose PCV20 or 1 dose PCV21 at least 5 years after the last pneumococcal vaccine dose . Review of R7's current M-Care Improvement Registry (MICR-State Agency-Immunization Record) R7's read in part: Pneumococcal High Risk (HR)/Adult. R7 received on 05/29/12 PPSV23. on 09/23/15 PCV13 (Prevnar13) . Consider 09/23/2020. Resident #28 (R28) Review of MDS dated [DATE], revealed admission to the facility on 7/22/25, with diagnoses that included: coronary artery disease (a heart condition caused by plaque buildup that restricts blood flow to the heart) and hypertension (condition where the force of blood against artery walls is consistently too high). Further review of Section C: Cognitive Patterns revealed R28 is rarely or never understood and requires supervision and cues to make decisions. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility document titled Universal Vaccination Consent Form revealed the Durable Power of Attorney (DPOA) consented for R28 to receive the pneumococcal vaccination on 10/15/25 Review of MCIR dated 3/3/26 revealed R28 was overdue for the pneumococcal vaccination. During an interview on 3/2/26 at 2:32 p.m., the Director of Nursing (DON) reported the universal consent for the immunizations is offered upon admission, annually for the residents who reside at the facility, and when there is a change in the recommendations for vaccines. If the resident/responsible party signs the consent and agrees to any vaccination, I review the MCIR and order the vaccinations from our pharmacy. The vaccines only take two days to arrive at the facility after the vaccines have been ordered. The only vaccination we have on site is for the flu. I would think that if the resident or responsible party request the vaccination, they would be able to have it administered to them within three days from the request sent to the pharmacy. During an interview on 3/3/26 at 3:23 p.m., Director of Nursing (DON) reported, I did not recognize immunizations were not being completed after consents were signed.we found that at the end of February of 2026 the immunizations were not being given. During an interview on 3/3/36 at approximately 3:30 p.m., the Assistant Director of Nursing (ADON)/Infection Preventionist reported, I realized I was not keeping track of the immunizations or consents that were signed for the residents who wanted to receive vaccinations the end of last month. Review of policy titled Pneumococcal Vaccine date reviewed/revised 1/1/26, read in part .Each resident will be assessed for pneumococcal immunization upon admission.The resident/resident representative retains the right to refuse the immunization.A consent form shall be signed prior to the administration of the vaccine.