STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235589	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakeland Center	26900 Franklin Road Southfield, MI 48034

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. This citation pertains to intakes 2615522, 2645363, and 2671721. Based on interview and record review, the facility failed to ensure that nursing staff received the required skills/competencies/performance evaluations for five of five Certified Nursing Assistants (CNA Y, Z, AA, BB, and CC) reviewed for education/training. Findings include:On 2/11/26 at 8:06 AM, the facility was requested via email to provide the CNA (Certified Nursing Assistant) skills competencies for CNAs (Y, Z, AA, BB, and CC).Review of the documentation provided by the facility revealed:CNA ?Y's most recent skills competency evaluation was completed on 7/18/24.CNA ?Z's most recent skills competency evaluation was completed on 8/8/24.CNA ?AA's most recent skills competency evaluation was completed on 1/23/24.CNA ?BB's most recent skills competency evaluation was completed on 11/2/22.CNA ?CC's most recent skills competency evaluation was completed on 6/27/24.On 2/11/26 at 12:45 PM, an interview was conducted with the Infection Preventionist / Staff Development (Nurse ?C'). They reported they had been in their role as Staff Development since mid October (2025). When asked about the facility's process for ensuring nurse staffing skills competencies were completed, Nurse 'C' reported they did reconcile the skills competency were done upon hire. When asked if they completed annual skills competency evaluations to determine areas that might need improvement, Nurse 'C' reported they were not aware those needed to be completed annually. When asked if there was any oversight from corporate for support, Nurse 'C' reported they did and was unable to offer any further explanation.According to the policy titled, Skills Evaluations dated 2/9/2024: .The skills evaluation checklist(s) is completed during job-specific orientation, re-validated annually, and completed as needed .

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 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 maintain an effective Quality Assurance and Process Improvement (QAPI) Program that identified multiple systemic issues that needed improvement and correction. This had the potential to affect all residents who resided in the facility. Findings include:On 2/11/26 at 2:55 PM, an interview was conducted with the Administrator regarding the facility's QAPI program. Systemic issues identified during the survey were discussed at that time. When queried about whether the facility's environment/housekeeping was identified as an issue through the facility's QAPI program, the Administrator said it was not identified. When queried about whether competency evaluations not being completed for Certified Nursing Assistants (CNAs) was identified, the Administrator said it was not identified through QAPI. When queried about whether it was identified that the facility did not have a Compliance and Ethics program that met the regulatory requirements and the facility policy, the Administrator reported it was not identified. When queried about whether staff members using electronic signatures and signing resident's names instead of their legal guardians was identified, the Administrator said it was not. When queried about whether it was identified that risk/benefit education was not provided prior to obtaining consent for immunizations, the Administrator reported it was not identified through QAPI. A review of a facility document titled, Quality Assurance Performance Improvement (QAPI) Plan), dated 10/15/18, revealed, in part, the following, .The scope of QAPI include the following .Maintenance .Housekeeping .Medical Record Integrity .Nursing Services .Call Light Response .All performance improvement opportunities will be prioritized based on safety and prevalence including high-risk, high-volume, or problem-prone areas . Cross-referenced tags: F551, F584, F725, F726, F883, F895

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the required committee members attended the Quality Assessment and Assurance (QAA) meetings at least quarterly. This had the potential to affect all residents in the facility. Findings include:A review of a facility policy titled, Quality Assurance Performance Improvement (QAPI) Plan dated 10/15/18, revealed, the following, .The QA Committee shall be interdisciplinary and shall: .Consist at a minimum of . The director of nursing services .The Medical Director or his/her designee . At least three other members of the facility's staff, at least one of which must be the administrator, or other individual in a leadership role .The infection control and prevention (ICP) officer, or designee .On 2/11/26 at 2:55 PM, an interview was conducted with the Administrator regarding the facility's QAA program. The Administrator reported that the QAA committee met monthly. At that time, a review of QAPI Committee Attendance Sign in Sheets from May 2025 through January 2026 revealed the following:On 5/7/25, the ICP did not attend the meeting (as evidenced by no sign-in on the attendance sheet). On 6/26/25, the Administrator and ICP did not attend the meeting.There was no sign-in sheet for July 2025 or August 2025.On 9/18/25, the Administrator and ICP did not attend the meeting.On 10/16/25, the Administrator and ICP did not attend the meeting.On 11/13/25, the Administrator and ICP did not attend the meeting.The Administrator did not have an explanation for why her name was not on all of the sign-in sheets and reported she may have forgot to sign in. The Administrator reported the facility did not have an ICP in May 2025 but did not have an explanation for the absence of an ICP on the other dates.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility.Findings include:On 2/9/26 at 10:20 AM during an interview with Maintenance Director (MD) G he indicated that he started at this facility this past September. When asked to describe the Water Management Program (WMP) he indicated that they were putting it together and when asked who was on the Water Management Team (WMT) that it would be himself and one other maintenance staff person. When asked about any monitoring of the water system, he indicated daily water temperature checks throughout the facility. When asked about any flushing protocols to prevent stagnant water he indicated none. He explained that the hot water tanks are drained and refilled monthly. He also indicated no monitoring of chlorine levels or other control measures at this time.On 2/9/26 at 10:45 AM during a building tour with Housekeeping Director (HD) H observations included Unit 2 and Unit 3 shower rooms which contained therapy tubs connected to the water supply. When interviewed at this time HD H indicated he hasn't seen them used. On 2/9/26 at 11:00 AM during a building tour with HD H observation of Units 1-4 Soiled Linen rooms had hoppers with spray arm attachments. Three of the four hoppers worked when flushed. Unit 1 hopper had a sign on it indicating do not use. When handle was pushed it did not flush, the water had been turned off to this fixture. When interviewed at this time HD H indicated these hoppers and spray arms were not used.Record review of documents in the WMP binder included a stack of monthly reports (2023-2025) provided by a water treatment contractor indicating that a Corrosion Control/secondary treatment service was in place and being serviced by this company.On 2/9/26 at 1:30 PM during an interview with the Nursing Home Administrator (NHA) when asked about the water treatment contractor, she indicated that she thought they were providing a testing service and was not aware of a treatment system in place. She explained that the previous maintenance director is at another facility and can provide additional information and that she would reach out to him. When asked about the Water Management Team, she indicated that any water issues were discussed as part of monthly QAPI meetings.On 2/9/26 at 2:30 PM, during an interview with NHA, MD G and former MD K (via phone), MD K indicated that the corrosion control system has been in place since before he started at the building in 2021. He indicated he would be checking with the vendor about any permitting records and will provide additional information on site tomorrow. On 2/9/26 at 2:45 PM observation of the corrosion control system in operation, including MSDS product sheets (sodium silicate), product storage, tubing, and injection into the cold water distribution piping upstream of the mixing valve. This was with NHA and MD G and confirmed that the treatment system was operating at this time. Record review of WMP documentation noted several missing elements, including: no text description of the water system, no comprehensive assessment of where Legionella and other opportunistic waterborne pathogens (OOWP) can grow and spread; no measures indicated to prevent the growth of Legionella and OOWP in the building water systems that is based on nationally accepted standards, no documentation of any visible inspections, disinfectant levels, or flushing protocols to prevent stagnant water.Record review of Legionella Water Management Program, Revised July 2017 which was included in the WMP binder does not contain the name of the facility nor any site-specific information, or evidence that the policy has been reviewed and updated annually. This policy document indicates that the WMP will include the following elements: an interdisciplinary team, a detailed description and diagram of the water system, identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, identification of situations that can lead to Legionella growth, specific measures used to control the introduction and/or spread of legionella, control limits that are acceptable and monitored, a diagram of where control measures are applied, a system to monitor control limits, a plan for when control limits are not met, and documentation of the program.

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a Compliance and Ethics Program. Based on interview and record review, the facility failed to maintain and implement an effective and operational compliance and ethics program for three (R6, R88, and R3) of three residents reviewed for binding arbitration, resulting in staff signing resident's names on legally bindings documents without their consent. This could potentially affect all residents who resided in the facility. Findings include: A review of a facility policy titled, Compliance and Ethics Program Policy dated 11/1/19, revealed, in part, the following: .As part of the facility's culture of compliance, the facility provides development and distribution of written standards of conduct, polices, procedures and protocols that promote the facility's commitment to compliance with areas of potential fraud and abuse, quality of care issues .The facility has adopted appointment of a Compliance Officer .and a Compliance Committee .charged with the responsibility for developing, operating and monitoring the Compliance & Ethics Program. Each facility's Administrator is designated as the onsite Compliance Liaison .The facility also enforces development and implementation of regular, effective education and training programs for all employees .The facility regularly uses audits and quality assurance to monitor compliance, identify problem areas, and assist in the reduction of identified problems .The facility continually revises and promotes the development of policies that initiate prompt response to detected offenses with the development of corrective action, repayments and preventative measures .Compliance .Written compliance and ethics standards, policies, and procedures and staff education of such .Assigned individuals within the high-level personnel of the facility with the overall responsibility to oversee compliance with the facility's compliance and ethics program standards, policies and procedures .The Compliance & Ethics committee will be compromised of both members of various disciplines such as: CEO (Chief Executive Officer), Nursing, Social Services, IT (Information Technology), rehabilitation, licensed Administrator and billing .As part of an operating organization with multiple facilities, additional components of the facility's compliance and ethics program include .mandatory annual training program on the facility's compliance and ethics program .A designated compliance officer in which the program is their main responsibility .Designated compliance liaisons located at each of the organization's facilities (The Compliance Liaison is the Administrator in each building) .The Compliance Officer as well as the facility Administrator and the facility In-Service ADON (Assistant Director of Nursing) review the compliance and ethics program minimally on an annual basis, revising as needed .The Compliance Officer will conduct random Quality Assurance audits in each facility .An annual binder will be kept in the Administrator's office containing all documentation supporting facility efforts to ensure continued Compliance and Ethical implementation of patient care, state and federal regulations as well as facility policies .The facility designates: employee orientation, employee in-services, the employee bulletin board as well as an employee Compliance Policy Binder located in the breakroom as a centralized resources for distributing information . On 2/11/26 at 11:45 AM, an interview was conducted with Admissions Director (AD) 'A' to discuss the facility's process for explanation and receiving consent for binding arbitration agreements (binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds). At that time Arbitration Agreements for R3, R6, and R88 were reviewed with AD 'A'. The Arbitration Agreements were all electronically signed by the residents. However, R3, R6, and R88 all had legal guardians and were deemed incompetent to make informed decisions for themselves. It was also discovered that there was an electronic signature by R3 on a Consent to Medical Care and Treatment form and an electronic signature by R6 on all financial and medical consents and documents included in the admission Packet provided on admission into the facility. R3, R6, and R88 would not have been able to understand what they were signing. When queried, AD 'A' reported when the signature section on the forms was clicked in the Electronic Medical Record (EMR) it automatically electronically signed the (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	forms with the resident's names. AD 'A' reported R3, R6, and R88 did not actually sign the forms themselves, and the signature was entered by AD 'A'. On 2/11/26 at 12:15 PM, an interview was conducted with the Administrator. The Administrator was unaware that residents with legal guardians who were unable to make their own decisions had their names electronically signed by staff and said staff should never sign a resident's name on any agreement or contract. At that time, the Administrator was asked to provide all documentation of the facility's Compliance and Ethics program, to include education, audits, committee members, etc. At that time, the binders referred to in the facility's policy were also requested. The Administrator reported she was going to look into it. On 2/11/26 at 2:01 PM, an interview was conducted with the Corporate Compliance and Security Officer (CCSO 'GG'). CCSO 'GG' explained she was the compliance officer for the corporation, and the Administrator was the Compliance Liaison for the facility. CCSO 'GG' reported she was in the process of revising and updating all of the policies related to the Compliance and Ethics program and was putting them online for each facility. CCSO 'GG reported she would email the policies. When queried about where the education, audits, and any information about the Compliance and Ethics program specific to that facility would be, CCSO 'GG' reported the Administrator would have additional information. When queried, CCSO 'GG' was unaware that staff were electronically signing residents' names on legally binding contracts and agreements. CCSO 'GG' emailed multiple links to a Corporate Compliance electronic manual. However, the documents were unable to be accessed. CCSO GG reported a staff member was going to print the documents and provide them. No additional documents were provided prior to the end of the survey. On 2/11/26 at 2:27 PM, the Administrator was further interviewed regarding the Compliance and Ethics Program. The Administrator reported CCSO 'GG' was helping her get things together. The Administrator reported she did not have a binder in her office or the breakroom according to what was documented in the policy, did not conduct any audits, or provide any education. Cross-reference tag: F551

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2603176, 2610188 and 2671721.Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, safe, and homelike environment, affecting all residents that reside on the second floor, including R20, R23, R24, R39, R51, R72, R96, and R103 and residents that utilize the shower rooms on all units. Findings include:Review of the complaints reported to the State Agency included multiple concerns regarding the facility's environment, including safety, cleanliness, and lingering odors. On 2/9/26, during a building tour with the Director of Housekeeping & Laundry (Staff 'H') the following observations were made: On 2/9/26 at 10:45 AM, in the Unit 4 first floor shower room observed a vinyl fabric liner attached under the shower bed full of cloudy liquid with odor of urine; HM H tipped the bed over the shower floor drain to drain away the waste liquid through the liner drain hole with attached tubing. The vinyl liner was then observed to be visibly soiled/stained with brown staining. During this observation, when asked if this liner was laundered, he indicated is not a laundered item and that housekeeping doesn't clean this item, it is the responsibility of the CNA (Certified Nursing Assistant) to clean this item. On 2/9/26 at 11:00 AM, in the Unit 3 shower room (room [ROOM NUMBER]) observed a therapy tub connected to the water supply. The floor was visibly soiled with buildup under and around the therapy tub. At the floor/wall juncture around the perimeter of the tiled shower observed torn and missing caulk seal and visibly soiled with black substance. The shower bed liner (catchment beneath the bed) also observed soiled/stained with a large brown area around the drain hole area connected to tubing. During this observation, when asked, HM H indicated he had not seen the tub be used. HM H also observed the soiled shower area and confirmed that it needed re-caulking and cleaning to remove the staining. When asked about the frequency of cleaning of shower rooms, he indicated that housekeeping staff cleaned all shower rooms daily with a deep/detail cleaning monthly. On 2/9/26 at 11:10 AM, in the Unit 2 shower room observed the floor visibly soiled with buildup under and around therapy tub. At the floor/wall juncture around the perimeter of the tiled shower observed torn and missing caulk seal and visibly soiled with black substance. During this observation, when asked, HM H indicated he had not seen this tub be used either. He also observed this soiled shower area and confirmed that it needed re-caulking and cleaning to remove the staining. On 2/9/26 at 11:20 AM, in the Unit 1 shower room observed the vinyl fabric liner attached under the shower bed full of cloudy liquid with odor of urine; HM H tipped the bed over the shower drain to drain away the waste liquid. This vinyl liner was also visibly soiled/stained with brown staining. Floor area at floor/wall juncture around perimeter of shower room also observed with soil build up. Additional observations included: On 2/9/26 at 9:27 AM, R96's room was observed. The floor in the room was littered with debris and numerous stains near the head of the bed and around the nightstand. On 2/9/26 at 9:35 AM and 2/10/26 at 1:25 PM, R24's room was observed. The closet door, the wall (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adjacent to the closet door, and the wall adjacent to the room door were observed with a dried purple substance in streaks down the surfaces. On 2/9/26 at 10:31 AM, R91's room was observed to be cluttered. The floor was sticky with debris scattered throughout the floor and appeared as if it had not been mopped. On 2/9/26 at approximately 10:40 PM, R23 and R39's room was observed with a dirty floor. Food crumbs, including scrambled eggs were observed around R39's bed. Food crumbs and trash were observed on the floor beside R23's bed. The floor appeared as if it had not been mopped and was sticky. On 2/9/26 at 12:15 PM, observations of the second floor revealed upon exiting the elevator there were very strong urine and bowel movement odors present throughout the hallways on Unit 1 and Unit 2. The flooring in the hallway just outside of the room occupied by R20 was observed soiled with a clear, sticky substance. On 2/9/26 at 12:21 PM, R20's room was observed to have a strong urine odor. The resident was not in the room at this time, and the bed linens were removed from the bed. The wall near the door was observed to be heavily damaged with deep grooves and the floor molding just on the inside of the room, near the door was observed peeling back with exposed debris. There was various food debris and trash scattered on the flooring throughout the room. On 2/9/26 at 12:40 PM, R51's room was observed to have debris and trash on the flooring scattered throughout the room. When asked about housekeeping, R51 reported housekeeping came into the rooms but lately there was a lot of housekeeping turnover with the housekeepers and supervisor. On 2/9/26 at 1:04 PM the handrail observed across from the housekeeping closet was observed separated, with sharp mental and plastic edges exposed. The handrail near the main lounge on Unit 1 was observed to have a missing end cap which exposed sharp metal and plastic edges. A resident was observed trying to propel their wheelchair throughout the hallway and used their hand to pull along the area of the handrail that was exposed. On 2/10/26 at 9:02 AM, observation of the entire hallway for rooms 215-225 revealed a very strong urine odor that was pervasive throughout the hallway, including in the central shower room. Upon further observation of the central shower room, there was no evidence of the source of the urine odor. The wallpaper throughout the hallways were observed heavily soiled with purple and brown colored debris splattered throughout and some sections were peeled away from the wall. The flooring outside and inside R20's room remained covered with a clear, sticky substance and a mechanical lift was stored directly over the substance. The floor molding in R20's room remained peeled away from the wall. On 2/10/26 at 10:09 AM, an observation of R72's room was conducted. Food and litter debris were observed on the floor and under R72's bed. A pedestal fan was observed at the foot of R72's bed and the cage around the fan and the fan blades were observed with a large accumulation of gray dust and debris. At that time, an interview was conducted with R72. During the interview, R72 expressed complaints with the facility's housekeeping. They said when they first admitted a couple of years ago the housekeeping staff would sweep and mop the floor daily and lately, they have only been coming in (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	once a week. R72, said It's not sanitary. R72 then said the facility frequently has unpleasant odors. They said they usually refuse to go out to dialysis on Wednesdays but sometimes they go just to get away from the smell in the building. On 2/10/2026 at 1:09 PM, the housekeeping closet 212 door was observed opened and not secured. There were several containers of cleaning chemicals stored in the room. There was no housekeeping staff observed in the hallways nearby. On 2/10/26 at 1:11 PM, Housekeeper 'E' was observed walking to the unlocked closet and when asked about the closet being unsecured, they reported that should've been locked. On 2/10/26 at 1:16 PM, the handrail end caps and peeling, soiled wallpaper remained. The floor molding inside room [ROOM NUMBER] remained peeled away. On 2/10/26 at 1:17 PM, R96's room was observed. R96 was not in the room, nor were there staff present. The bed was stripped of the linens, and the linens were thrown on the floor under the window. At the foot of the bed, the floor was observed with copious amounts of skin flakes, and the floor near the nightstand was soiled with light brown, sticky stains. On 2/10/26 at 1:40 PM, R23 and R39's room remained in the same condition as mentioned above. The floor was dirty with food crumbs and scrambled eggs alongside R39's bed. A plastic spoon, medication cup, and food crumbs were on the floor beside R23's bed. At that time R23 was interviewed and asked how often the room was cleaned. R23 said they did not know but mentioned a nurse aide thought staff members were using the toilet in their room. At that time, an observation or R23 and R39's bathroom was conducted. Two wheelchairs were stored in the bathroom. A pink stain was observed on the toilet seat. The water in the toilet bowl appeared to have a film on the top and was discolored. The toilet bowl had black stains on it. On 2/11/26 at 8:10 AM, an interview was conducted with the Maintenance Director (Staff 'G') who reported they had started working at the facility in September 2025. When asked about how the facility staff notified maintenance of any items that might need to be addressed, Staff 'G' reported the facility staff utilized an electronic reporting system. At that time, Staff 'G' was asked to observe the environment on Unit 1 and Unit 2 and confirmed the same findings with the sharp handrails and missing end caps, floor molding, and peeling wallpaper. Upon observing the Unit 1 shower room, the shower bed was observed to have a lower white plastic shelf layer under the shower bed that was visibly soiled. Staff 'G' reported they had identified that yesterday and would be removed today. Upon further inspection of the shower bed, there was a metal object on the tile floor directly under the shower bed and a broken black zip tie to the left side of the shower bed. When asked about the metal object and broken zip tie, Staff 'G' reported that was a broken pin which secured the railing to one side of the shower bed rails. When asked if staff were aware it was broken, why was the shower bed still available for use, and further asked if Staff 'G' had been notified it needed repairs, Staff 'G' reported they were not aware of that, it should've been reported and not been available for use. When asked about the floor molding for room [ROOM NUMBER], Staff 'G' reported they had just seen that yesterday and had not been reported by any staff. On 2/11/26 at 8:26 AM, an interview was conducted with the Director of Housekeeping and Laundry (Staff 'H'). They reported they had been in their role for about a month. When asked about their staffing for the department, Staff 'H' reported there were several openings that needed to be filled. (continued on next page)

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The Lakeland Center	26900 Franklin Road Southfield, MI 48034

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	They further reported their housekeepers were assigned seven days a week from 7:00 AM to 3:30PM and they also had a night housekeeper who worked seven days a week from 3:00 PM to 11:00 PM. When asked about to explain their process of ensuring resident rooms and environment were adequately cleaned, Staff 'H' reported their staff used a checklist and cleaned all rooms daily. When asked about the earlier observations of housekeeping concerns as well as the multiple complaints from residents and families, Staff 'H' acknowledged there were concerns with housekeeping. When asked about the stains throughout the hallway on Unit 1 and 2, Staff 'H' confirmed the areas of concern and proceeded to use their nail on the brown stain on the wall and handrail across from the nursing station and stated that could be tube feeding residue. When asked why no one had addressed the areas since these were evident since the survey began on 2/9/26, Staff 'H' offered no further explanation. When asked about the storage of chemicals and informed of the observation with Housekeeper 'E', Staff 'H' reported that should not have occurred and the housekeeping closet should be locked at all times. On 2/11/26 at 2:25 PM, review of the electronic reporting documentation provided by the facility included four pages with dates from 9/23/25 - 2/9/26. None of the concerns mentioned above were included within this documentation. According to the policy titled, Homelike Environment dated 2/3/2026: .Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary, and orderly environment .pleasant, neutral scents .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment .Staff may assist in providing a safe and homelike environment by .reporting lingering odors and bathrooms needing cleaning to the housekeeping department .Reporting any unresolved environmental concerns to the administrator. According to the policy titled, Chemical Storage dated 5/7/2013: .It is the Center's Policy to store chemicals in a safe manner . On 2/9/26 at 9:27 AM, R96's room was observed. The floor in the room was littered with debris and numerous stains near the head of the bed and around the nightstand. On 2/9/26 at 9:35 AM and 2/10/26 at 1:25 PM, R24's room was observed. The closet door, the wall adjacent to the closet door, and the wall adjacent to the room door were observed with a dried purple substance in streaks down the surfaces. On 2/10/26 at 10:09 AM, an observation of R72's room was conducted. Food and litter debris were observed on the floor and under R72's bed. A pedestal fan was observed at the foot of R72's bed and the cage around the fan and the fan blades were observed with a large accumulation of gray dust and debris. At that time, an interview was conducted with R72. During the interview, R72 expressed complaints with the facility's housekeeping. The said when they first admitted a couple of years ago the housekeeping staff would sweep and mop the floor daily and lately, they have only been coming in (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	once a week. R72, said It's not sanitary. R72 then said the facility frequently has unpleasant odors. They said they usually refuse to go out to dialysis on Wednesdays but sometimes they go just to get away from the smell in the building. On 2/10/26 at 1:17 PM, R96's room was observed. R96 was not in the room, nor were there staff present. The bed was stripped of the linens, and the linens were thrown on the floor under the window. At the foot of the bed, the floor was observed with copious amounts of skin flakes, and the floor near the nightstand was soiled with light brown, sticky stains.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2610188. Based on observation, interview, and record review, the facility failed to ensure activity of daily living care (personal hygiene, bathing, nail care) for four residents, (R's 72, 6, 20, and 51) of six residents reviewed for activities of daily living, resulting in poor hygiene, body odor, complaints of not receiving care, and the potential for embarrassment from poor hygiene. Findings include: R72 On 2/10/26 at 10:09 AM, an interview was conducted with R72. R72 verbalized complaints that sometimes there were not enough aides on the unit. When queried why they thought the facility was short staffed they said, It takes a long time to get waited on, and further indicated they missed some of their scheduled bed baths. They said recently they went about a week without receiving a bed bath. On 2/10/26 at 10:12 AM, a review of R72's Certified Nurse Aide (CNA) task for bathing for a 30-day look-back period was conducted and revealed they received a bed bath on 1/21/26 and did not receive their next one until 1/28/26. The task form further revealed their last documented bed bath was completed on 2/3/26. R6 On 2/9/26 at 9:27 AM, R6 was observed sleeping in their bed in a hospital gown. The fingers on R6's left and right hands were contracted in a fist into the palm of their hands. R6's fingernails that could be observed (not all could be observed due to contractures) were long in length approximately 1.25 inches beyond the tip of the finger with debris under the nails. It was noted R6 had an unpleasant, sour body odor. On 2/9/26 at 12:08 PM, R6 was observed in their bed awake, dressed in a hospital gown. R6 did not respond to attempts at an interview and made only non-sensical grunting noises. The foul, sour odor persisted about the room. On 2/10/26 at 10:45 AM, an observation of R6 was made with Unit Manager 'X'. R6 was observed in the same gown as observed on 2/9/26. At that time, Unit Manager 'X' was asked about the foul odor in the room and confirmed the room had an unpleasant odor. They further said R6 was scheduled to receive a shower later on in the day. They were then asked if an observation of R6's right palm could be made to check skin integrity and ensure no sores developed in the palm from the long nails on R6's contracted fingers. Unit Manager 'X' was only slightly able to uncurl R6's fingers from their palm given R6's contractures and resistance, but when they did a very strong, foul, bitter, sour odor emanated from R6's hand. Unit Manager 'X' confirmed the odor was coming from R6's hand. They were asked how staff ensured R6's cleanliness and hygiene and said about a month ago, the therapy department was able to work with R6 to clean the palm of their hand. On 2/10/26 at 11:05 AM, an interview was conducted with Rehab Director 'I' regarding R6's hand contractures and hygiene for the hand. They indicated R6 was resistive for opening their hands but thought if they took enough time with R6 he would eventually let them clean the palm of the hand. On 2/10/26 at approximately 3:00 PM, R6 was observed in their room, dressed in a long sleeve shirt and fleece pants seated in their geri-chair. R6's nails were observed to remain long in length. Though (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	some of the strong odor had diminished in the room, the room and R6 remained with a sour, stale odor. A review of R6's CNA task for bathing for a 30-day look-back period was conducted and revealed their last scheduled shower was documented on 2/3/26. R6's clinical record further revealed they had severely impaired cognition and was dependent of staff for all activities of daily living. R20 Review of concern forms provided by the facility from R20's family included: 9/19/25.Notified by administrator that family called and was very upset that resident had not been dressed and still in bed. Writer went to staff to address problem and instructions were given to get resident dressed and in chair. Writer notified a hour later tasks had not been done. 9/9/25.Son reports delay in personal care on 9/8/25. Son reports resident in same clothing (facility gown) per resident. Son also reports a strong urine smell from bed which suggests she hasn't had any change in linen . Review of the clinical record revealed R20 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia unspecified without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and epileptic seizures related to external causes no intractable without status epilepticus. According to the MDS assessment dated [DATE], R20 had intact cognition, had no behaviors, had impaired functional limitation in range of motion on both upper and lower extremities, and was dependent for shower/baths and personal hygiene. Review of the care plans included: [R20] has an ADL Self-care deficit related to diagnosis of vascular dementia, Hx (History) of CVA (Cerebrovascular accident) with residuals, Left Hemiparesis, upper and lower extremity ROM (Range of Motion) impairment. Date Initiated: 06/28/2024. Interventions included: Assist [R20] to bathe/shower as scheduled and as needed via gurney x2 person assist. Date initiated: 10/16/2025. Review of the available shower/bath documentation for the past 30 days revealed R20 only had one shower documented on 1/14/26 at 12:52 PM. There were no documented refusals. R51 On 3/9/26 at 12:40 PM, an interview was conducted with R51 at bedside. When asked about whether they received their showers/baths as scheduled, the resident reported their preference was to get a shower but at times when there wasn't enough nursing staff, they received a bed bath or didn't get a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed R51 was initially admitted into the facility on 5/19/21, readmitted on [DATE] with diagnoses that included: generalized anxiety disorder, major depressive disorder recurrent moderate, adjustment disorder, other osteochondrodysplasia with defects of growth of tubular bones and spine, short stature due to endocrine disorder unspecified, and neuralgia and neuritis. According to the MDS assessment dated [DATE], R51 had intact cognition, was dependent on staff for assistance with toileting hygiene, required substantial/maximal assistance for shower/bathing, required partial/moderate assistance with upper body dressing, was dependent for lower body dressing, and was dependent for tub/shower transfers. Review of the resident's bathing/shower documentation in the electronic medical record revealed for the past 30 days, R51 received only three showers on 1/13/26, 1/20/26, and 1/30/26. There were no documented refusals. According to the ADL care plan initiated 5/19/21: SELF-CARE DEFICIT (ADLs): [R51] needs assistance with ADLs and bed mobility. [R51] is <sic> risk for ADL Decline related to [R51's] disease process. Performance deficit related to Activity Intolerance, Limited Mobility, and Limited ROM. Interventions/Tasks included: [R51] has a preference of shower chairs to be used as available. She prefers to use the gray shower chair. date initiated 5/7/25. On 2/10/26 at 2:02 PM and 4:40 PM and 2/11/26 at 8:16 AM, the facility was requested via email to provide the shower/bath schedules for all units. There was no further follow-up or documentation of this request provided by the end of the survey. On 2/11/26 at 8:43 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for documenting when shower/baths were provided, the DON reported the CNAs (Certified Nursing Assistants) were told everything should be documented in (electronic medical record). When asked if they used any other documents such as an actual shower forms, the DON reported they did not use additional forms and should be documented in (electronic medical record). A review of a facility provided policy titled, Activities of Daily Living (ADL) reviewed 2/2026 was conducted and read, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2615522, 2645363, and 2671721.Based on observation, interview, and record review, the facility failed to ensure there was sufficient nursing staff to meet the needs of the residents, resulting in delayed and/or lack of activities of daily living (ADL) care including incontinence care, dressing and showers/baths for residents that reside on the second floor, including R17, 27, 51, 54, 72, 96 and nine residents who wished to remain anonymous that attended the resident council interview. Findings include:Review of complaints reported to the State Agency included multiple concerns from residents, families and staff that the facility was not adequately staffed to meet the residents' needs.According to the facility's documentation of their staffing guidelines within the facility assessment last updated 1/15/26, .The facility's staffing is based on resident population and acuity. The following generally represents the daily staffing at the facility utilizing the number of employees .Unit 1 .Licensed Nurse 7a-7p .2 .7p-7a .1 .Nursing Assistant 7a-7p .3 .Unit 2 .Licensed Nurse 7a-7p .1-2 .7p-7a .1 .Nursing Assistant 7a-7p .2.Unit 3 .Licensed Nurse 7a-7p .1 .7p-7a .1-2 .Nursing Assistant 7a-7p .2.Review of the documentation provided by the facility which included assignment sheets with rooms assigned, census for each unit, as well as the time punch reports for all nursing staff that worked on 2/7/26 and 2/8/26 revealed there were multiple staff call-offs and the staffing assignments were not reflective of the above staffing levels identified in accordance with the facility assessment.On 2/9/26 at 9:50 AM, R54 was observed in their bed. They were asked about their stay in the facility and said the facility does not have enough staff. R54 said they have been left an entire shift without incontinence care. They further reported it was more prevalent on the night shift. They were asked if staff reported they were working short and R54 said, They always cry that. They further reported because of staffing they don't get their scheduled bed baths.On 2/9/26 at 10:02 AM, R17 was observed lying on their back and an interview was conducted with the resident at that time. R17 stated the facility did not have enough staff to provide care. R17 stated they missed therapy a lot because the facility did not have enough staff to get them ready for therapy.A review of R17's Physical Therapy notes revealed the following:9/1/25 . could not be seen due to BM (bowel movement) and later dinner, team will follow up tomorrow.8/23/25 . Pt (patient) received supine in bed with gown on, stating. Last time they did the therapy in the room. I would like that today because I am not dressed yet.On 2/9/26 at 12:40 PM, R51 reported their roommate's family (R27) repeatedly asks staff to make sure she is up but everyday the staff leaves her in bed. R51 further reported the facility frequently had only one nurse and two aides for the whole hallway and frequently have to wait for assistance longer than a half hour. R51 was asked if they had missed any activities of daily living such as showers due to not having enough nursing staff and they reported they missed multiple showers and will get a bed bath at times, but their preference is a shower. R51 further reported that due to the low nursing staff this past weekend, None of us got out of bed and meals were brought to eat in our rooms.On 2/10/26 at 9:18 AM, review the staffing assignment sheets for second floor included some residents that were documented as early get up which included rooms 280 bed A and bed B.On 2/10/26 at 9:25 AM, both residents in room [ROOM NUMBER] were observed lying in bed, not dressed and wearing hospital gowns.According to the current assignment sheet, there were supposed to be three CNAs assigned to Unit 1 on the North and South side.However, on 2/10/26 at 9:25 AM, Nurse ?O? was asked about the assignment sheet and reported CNA ?W' was not in yet. When asked who was covering their assignments, Nurse ?O' offered no further explanation.On 2/10/26 at 9:32 AM, Nurse ?R? was asked about the residents still in bed that were scheduled to be on the early get up list according to the assignment sheet and Nurse ?R? reported they had marked that on the assignment sheet so that the staff do get them up, but reported the CNAs typically do meals, get residents ready for appointments, then showers before they get residents out (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of bed. When asked what they considered as early, Nurse ?R' offered no further explanation.On 2/10/26 at 10:05 AM, an interview was conducted with the Director of Nursing (DON). When asked about who the facility's staffing scheduler was, the DON reported that person started yesterday. When asked who was handling it prior to that, they reported that was their Unit Manager (UM ?X?).On 2/10/26 at 10:09 AM an interview was conducted with R72 and expressed concerns regarding lack of staff. R72 was queried further and said sometimes there were not enough aides saying, It takes a long time to get waited on. They said sometimes there was only one CNA for all of unit one and part of unit two. R72 further reported last week they did not receive their scheduled shower or bed bath.On 2/10/26 at 11:00 AM, a Resident Council interview was conducted with nine residents who wished to remain anonymous. When queried about any concerns about care in the facility, the following concerns were expressed by five of the residents:One resident reported the staff did not answer the call lights in a timely manner. The same resident reported due to there not being enough staff, they are forced to receive a shower at whatever time the certified nursing assistants (CNA) give it to them rather than at their preferred time. A second resident reported there were only two CNAs and two nurses at times on the second floor, and they worked on multiple units. That resident reported the CNAs said, Be there in a minute. but they did not return for hours. That resident further reported last Saturday they had to take a shower at 6:00 AM due to short staff and that was not their preferred time. A third resident reported they were left in bed this past weekend from the time they were put in bed until 1:00 or 2:00 PM the following day. They required assistance from staff to get out of bed. They typically liked to spend their days out of bed and in their wheelchair. That same resident reported there was another weekend when they were left in bed for two whole days. A fourth resident stated, The midnight shift disappears and reported when they rang the buzzer it often took hours and hours to get help. A fifth resident reported they also experienced long call light response and felt there were not enough nursing staff. On 2/10/26 at 11:34 AM, an interview was conducted with the Human Resources / Payroll (Staff ?V'). When asked about the facility's open nursing positions, Staff ?V' reported they were constantly hiring and expressed challenges with three different staff in the scheduler position.On 2/10/26 at 12:01 PM, a phone interview was conducted with Certified Nursing Assistant (CNA ?S?). When asked about the staffing for this past weekend, they reported there were multiple call-offs on Sunday. When asked if anyone from management came in to assist, they reported sometimes that happened but that did not happen this past Sunday. When asked if they were able to complete all their tasks when they worked with less staff, CNA ?S' reported they were not.On 2/10/26 at 1:04 PM, an interview was conducted with R96. R96 said the facility was short nurses on the night shift. They further reported the facility has nurses on staff to pass the nighttime medications, but then most of them are sent home after the medications have been passed.On 2/11/2026 at 8:59 AM, an interview was conducted with the Administrator. When asked about the concerns reported by multiple residents, families and staff in regard to lack of adequate nurse staffing, the Administrator reported there were challenges and they've hired a lot of people.On 2/11/26 at 8:43 AM, an interview was conducted with the DON. When asked about the concerns with lack of adequate nursing staff, the DON reported they had the appropriate staff assigned, but the call offs were excessive. The DON reported their facility has been doing mass hirings and just had a new weekend supervisor start three days ago. When asked about the staffing ratios for Unit 1, the DON reported Should have three CNAs on day shift and acknowledged the staffing documentation they provided to review confirmed there were not.According to the facility's policy titled, Staffing dated 4/18/2025: .Licensed nurses and nursing assistants are available 24 hours a day, ,seven days a week to provide competent resident care services including.Responding to resident needs.Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments, and the facility assessment.Inquiries or concerns related to the facility's staffing should be directed to the Administrator or their designee.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. This citation pertains to Intake #'s 2615522 and 2610188. Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than five percent when five errors were made from 25 opportunities for two residents (R#'s 57 and 92) of three residents reviewed during the medication administration task, resulting in a medication error rate of 19%. Findings include: R57On 2/11/26 at 8:30 AM, Nurse 'EE' was observed preparing medications for R57. Among the medications prepared, Nurse EE prepared a magnesium oxide (supplement) 400 mg (milligram) tablet, a folic acid (supplement) 400 mcg (microgram) tablet, and a gabapentin (neuropathy medication) 100 mg capsule. Nurse 'EE' then crushed all the medications including the gabapentin capsule, mixed them with applesauce, entered R57's room and administered them. Upon the completion of the administration, Nurse 'EE' confirmed all medications due at that time were administered to R57. Nurse 'EE' was asked about crushing the gabapentin capsule as opposed to emptying the capsules content and discarding the outside capsule halves and said they did not see a warning in the electronic medical record that advised them it could not be crushed. On 2/11/26 at 9:40 AM, the medications administered by Nurse 'EE' to R57 were reconciled (compared) with the physician's orders. During the reconciliation it was discovered R57's order for magnesium oxide dated 6/26/25 was to administer 440 mg. It was further discovered R57's order for folic acid dated 6/26/25 was to administer 1 mg as opposed to the 400 mcg dose observed to be administered to R57. Continued review of the physician's orders revealed R57 had an order dated 6/26/25 for famotidine (for gastroesophageal reflux) 20 mg that was not observed to be prepared and administered to R57 during the observation. On 2/11/26 at 8:43 AM, Nurse 'FF' was observed preparing medications for administration to R92. Among the medications prepared was a sennosides (laxative) 8.6 mg tablet. After preparing the medications, Nurse 'FF' entered R92's room and administered the medications due at that time. On 2/11/26 at 9:30 AM, the medications administered by Nurse 'FF' to R92 were reconciled with the physician's orders. It was discovered R92 did not have an order for 8.6 mg of sennosides laxative, rather; they had an order dated 1/15/26 for Senna-S, a combination medication containing sennosides 8.6 mg combined with 50 mg of docusate sodium (stool softener). On 2/11/26 at 10:23 AM, an interview was conducted with the facility's Director of Nursing. They were asked about Nurse 'EE' crushing the gabapentin capsule and said it should not be crushed, rather the contents of the capsule should have been emptied from it. They were then asked about how, in general; nurses should administer medications and they reported medications should be administered per the 5-rights of medication administration (Right resident, Right medication, Right dose, Right Route, Right time). A review of a facility provided policy titled, Medication Administration reviewed 2/2026 was conducted and read, Policy Overview: To safely and accurately prepare and administer medication according to physician order, professional standards of practice and resident needs .Medications are administered in accordance with the following rights of medication administration: Right resident, Right medication, Right dose, Right route, Right time and frequency, Right documentation .Do not crush medication when contraindicated or without a physician's order .

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure decision making was exercised by residents' court-appointed representatives for three (R3, R6, and R88) of three residents reviewed for arbitration. Findings include:R3 On 2/9/26 at 10:48 AM, R3 was observed lying in bed sleeping. R3 had a tracheostomy (a tube surgically inserted into the windpipe to assist with breathing) and a feeding tube delivering nutrition into a surgically inserted tube into the stomach. When addressed, R3 did not open her eyes. R3 was unable to participate in an interview. A review of R3's clinical record revealed R3 was admitted into the facility on 9/15/25 and most recently readmitted on [DATE] with diagnoses that included: epilepsy, respiratory failure, aphasia (difficulty speaking), and dysphagia (difficulty swallowing). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R3 had severely impaired cognition and was dependent on staff for all activities of daily living. Further review of R3's clinical record revealed R3 had a court-appointed legal guardian who made decisions for the resident due to the resident being incapable of making their own decisions. A review of a Consent to Medical Care and Treatment form for R3 revealed the form was E-signed (electronically signed) by R3 and not their legal guardian. The form documented, The Resident and/or Resident's Representative consent to and request medical care and treatment at the Facility . A review of an Arbitration Agreement (binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) for R3 revealed it was E-signed by R3 on 9/16/25. The form also included R3's electronically entered initials acknowledging each section of the arbitration agreement. The form documented, You have the opportunity to ask questions before signing this document .The Resident/Resident's Legally Authorized Representative, by signing this agreement, also acknowledges that he/she has been informed and understand that: .b. The agreement may not be submitted to a Resident for approval when the Resident has been deemed incompetent by two physicians. c. The decision whether or not to sign the agreement is solely a matter for the Resident's (or the Resident's legally authorized representative) determination without any influence. d. The agreement waives the Resident's right to trial in court for any future malpractice claim the Resident may have against the healthcare provider, absent revocation of the agreement consistent with state law . The form was then signed by Admissions Director 'A'. There was no evidence the legal guardian was provided these documents. R6 On 2/9/26 at 12:08 PM, R6 was observed lying in bed, awake and alert. When addressed R6 made noises but was unable to have a sensical conversation. R6 was unable to be interviewed. A review of R6's clinical record revealed R6 was admitted into the facility on 1/7/22 and most recently readmitted on [DATE] with diagnoses that included: secondary parkinsonism, paranoid schizophrenia, dysphagia, epilepsy, and bipolar disorder. A review of a MDS assessment dated [DATE] revealed R6 had severely impaired cognition. Further review of R6's clinical record revealed R6 had a court-appointed legal guardian who made decisions for the resident due to the resident being incapable of making their own decisions. A review of an Arbitration Agreement for R6 revealed it was E-signed and initialed by R6 and not their legal guardian on 10/31/25. The form was then signed by Admissions Director 'A'. R88 On 2/9/26 at 10:21 AM, R88 was observed lying in bed. An interview was attempted. R88 did not speak when questions were asked and did not make direct eye contact. R88 was unable to be interviewed. A review of R88's clinical record revealed R88 was admitted into the facility on [DATE] with diagnoses that included: dementia, diabetes, hypertension, aphasia, and hemiplegia. A review of R88's MDS assessment dated [DATE] revealed R88 had severely impaired cognition. Further review of R88's clinical record revealed R88 had a court-appointed legal guardian who made decisions for the resident due to the resident being incapable of making their own decisions. A review of a Resident admission Application (admission (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	packet) for R88 revealed all consent and documents, including financial consent and medical consents, were signed by R88 on 10/22/25 and not their legal guardian. A review of an Arbitration Agreement for R88 revealed it was signed and initialed by R88 and not their legal guardian on 10/22/25. The form was then signed by Admissions Director 'A'. On 2/11/26 at 11:45 AM, an interview was conducted with Admissions Director (AD) 'A'. When queried about how the binding arbitration agreements and any admission consents and/or documents were presented to resident's or their legal representatives, AD 'A' reported on admission they met with the resident and/or their resident representative to go over the admission contract, consent to treat, and binding arbitration agreements. AD 'A' said she explained what the arbitration agreement was in detail and ensured they understood what they were signing. AD 'A' further reported residents and/or their representatives were not required to sign the arbitration agreement in order to receive care in the facility. When queried about how they determined if the resident's physical condition and cognitive status affected their ability to understand and make an informed and appropriate decision, AD 'A' reported if she questioned the resident's cognitive status, they had the resident assessed by social services and waited for a capacity evaluation. When queried about electronic signatures and how they were initiated, AD 'A' reported they were generated in the electronic medical record and if the resident did not have a legal representative when she clicked on the signature section it automatically entered the resident's name and E-signed it and there was no option to opt out. When queried about how R3, R6, and R22 were able to E-sign the arbitration, consent to treat, and admission documents if they were unable to understand or make decisions for themselves, AD 'A' reported they did not actually sign the documents themselves. On 2/11/26 at 12:15 PM, an interview was conducted with the Administrator. When queried about the facility's protocol for signing documents such as arbitration agreements, consent to treat, and/or admission contracts, the Administrator reported it was discussed and presented on admission and if a resident had a legal guardian, it would be discussed with them, and they would be responsible to sign the documents. The Administrator was not aware of the use of electronic signatures and reported if the resident was unable to sign or if a resident or representative did not want to sign the agreements and/or contracts, it was just left blank or documented that they refused. The Administrator reported staff should never sign a resident's name on any agreement or contract.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. This citation pertains to intake #2615522. Based on observation, interview, and record review, the facility failed to promote resident self-determination through support of resident choice for two residents (R72 and R96) of two residents reviewed for self-determination and resident choice resulting in frustration, verbalized complaints, and the withholding of occupational therapy rehab services. Findings include:R72 On 2/10/26 at 10:09 AM, R72 was observed in their room. At that time, an interview was conducted regarding an allegation lodged with the State Agency regarding the facility's refusal to apply a seat belt to R72's wheelchair. They explained that when they used to go to their outpatient day program, they were allowed to have a seatbelt in their wheelchair, which gave them a sense of security and safety. They continued to explain that since they stopped attending the outpatient day program (in the summer of 2025) they had been given a different wheelchair and the facility repeatedly refused to equip it with a seatbelt upon their request. They continued to say they were physically able to unbuckle the seatbelt on their own free will and did not understand why they were no longer allowed to have one. They were asked who in the facility they requested the application of the seatbelt on their new wheelchair and said they inquired with both Rehab Director 'I' and Maintenance Staff 'N'. They were asked what the facility's reply was when they were told they could not have seatbelt and said, They told me the State doesn't allow it, but I know that's a lie.On 2/10/25 11:05 AM, an interview was conducted with Rehab Director 'I'. They were asked if they were aware of R72's request for the application of a seatbelt on their new wheelchair and they denied any knowledge of R72's request. Rehab Director 'I' said they would look into R72's request and perform an assessment. On 2/11/26 at 12:15 PM, an interview was conducted with the facility's Administrator, and they were made aware R72 had been told by staff they could not have a seatbelt in their wheelchair because, The State doesn't allow it. The Administrator indicated this was an inappropriate response to R72's request and said they had been made aware of R72's request from Rehab Director 'I' on 2/10/26 and they were going to have R72 assessed for the proper use of a seatbelt in their wheelchair. R96On 2/11/26 at 1:04 PM, an interview was conducted with R96. R96 verbalized complaints about rehabilitation services. They said they have frequent transfers out to the hospital and when they return to the facility from an admission at the hospital, Physical Therapy (PT) comes to assess them, but they refuse the Occupational Therapy (OT) assessment. They continued to say they don't want PT services, but they would like OT services. When queried why they were not getting OT services they said they did not like Certified Occupational Therapist Assistant (COTA) 'DD' and refused treatment from them but would be willing to work with another therapist. They said they were told by Rehab Director 'I' COTA 'DD' was the only COTA on staff. The further said, Rehab Director 'I' said they would come in and supervise COTA 'DD' when working with them, but it didn't matter because they (R96) still did not want COTA 'DD' performing the therapy. On 2/11/26 at approximately 1:30 PM, a facility provided Concern Form initiated by R96 on 9/3/25 was reviewed and read, .Describe the concern using factual terms: Reports that he would like a different OT for his therapy .Action taken regarding the concern: Spoke with Resident & COTA separately. Plan to have Therapist and DOT (Director of Therapy, Rehab Director 'I') attend next OT tx (treatment) & determine if common ground can be found to continue with OT tx . A review of R96's progress notes revealed the following:A note entered into the record on 10/7/25 from COTA 'DD' that read, .Ot {sic} attempted OT evaluation as pt (patient) has returned from the hospital. Pt refused ot {sic} evaluation .Pt stated when the department hires a new therapist then let him know . A note entered into the record by Rehab Director 'I' on 2/10/26 that read, Attempted OT eval on this date with resident declining, stating, I'm not feeling up to it and I want to wait till you get a new (OT). Suggested to resident to agree to OT assessment and trial treatment with the current OT team. Resident again declined.On 2/10/26 at 2:19 PM, an interview was conducted with Rehab Director 'I'. They were asked why R96 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was refusing OT services and said R96 did not like COTA 'DD'. They were asked what they were doing to accommodate R96's preferences for an OT service provider and said they (Rehab Director 'I') offered to be present with COTA 'DD' during the therapy sessions, however; R96 continued to decline services provided by COTA 'DD'. Rehab Director 'I' was asked if they could provide the therapy services since they were a licensed OT and said they could not promise to do all sessions as the role of Rehab Director had too many other things going on. They were then asked if the Rehabilitation Contract Company could send another COTA that worked for the company and said they didn't think they would send someone out for one resident. On 2/11/26 at 12:15 PM an interview was conducted with the facility's Administrator. They were asked if they were aware of R96's ongoing concerns with OT services, particularly with COTA 'DD' and said they said they were not, but they should have been made aware, and something should have been done to accommodate his preferences. A review of a facility provided policy titled, Accommodation of Needs reviewed 2/2026 was conducted and read, The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preference of a resident .The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2671721. Based on observation, interview and record review, the facility failed to ensure freedom from neglect for one resident (R96), of four residents reviewed for neglect resulting in R96's frustration and complaints that staff do not tend to their needs/requests when they activate their call light. Findings include: On 2/10/26 at 1:30 PM, a review of facility provided, Concern Form dated 8/4/25 reported from R96 was interviewed and read, Describe concern using factual terms: Resident alleges when call light is pressed staff turn of {sic} call light from desk without completing the task .[NAME] taken regarding concern: Verbal statement from nurse during Admin (Administrator) investigation: Nurse admitted to turning off call light without addressing issues. Staff educated on call light response .Nurse provided one-on-one . On 2/11/26 at 12:15 PM, an interview was conducted with the facility's Administrator regarding R96's concern form. They were asked if they recalled the incident and to identify the nurse that admitted to turning off R96's call light without tending to their needs/request. The Administrator indicated they remembered the incident and identified Nurse 'O'; who admitted to turning off the call light from the nursing station without going to check why R96 activated the call light. On 2/11/26 at 12:36 PM, R96 was observed in their bed with a specialized, breath activated call light designed for patients with limited or no motor skills, such as quadriplegia. A that time, an interview was conducted with R96 regarding staff turning off the call light from the nursing station desk without tending to their needs/request and reported staff were still doing it. When they were asked how they knew the call light was deactivated from the nursing desk they explained that when the light is activated a bell sounds in the hallway, and when the bell stops sounding, and no one comes to their room the light was deactivated from the nursing station. R96 further reported, in the past the Administrator had been in their room, activated the call light and witnessed staff deactivating it without coming into the room to check why it was activated. A review of R96's clinical record revealed they admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnoses that included: quadriplegia, peripheral vascular disease, chronic pain, pressure ulcers, neuromuscular dysfunction of the bladder, presence of a suprapubic catheter, and urinary tract infections. A review of a facility provided policy titled, Abuse updated 5/2023 was conducted and read, .Residents have the right to be free from abuse, neglect, exploitation, mistreatment .Definitions: Neglect .Failure of the facility, it's employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers: 2671563, 2671721. Based on observation, interview and record review, the facility failed to report an injury of unknown origin and an allegation of neglect to the Abuse Coordinator and State Agency, and failed to report resident to resident physical abuse to the State Agency without misleading information that minimized the seriousness of the incident for three (R22, R76, and R96) of five residents reviewed for abuse and neglect. Findings include: R22 and R76 A review of a Facility Reported Incident (FRI) revealed on 11/3/25, the facility reported the following to the State Agency: physical contact made by resident (R22) to resident (R76) .Resident (R22) placed on one-on-one supervision .Investigation initiated . The report did not document the type of physical contact that was made. A review of R76's progress notes revealed a Nursing-Progress Note dated 11/3/25 that documented, Writer called to the unit for an incident involving res (resident) and another resident from unit, staff CNA (Certified Nursing Assistant) stated res was in dining area in wheelchair when another res rolled up and grabbed res by the collar and pulled her to the floor, incident was witnessed .had pain in R (right) arm and hip area . A review of an investigation file provided by the facility into the resident-to-resident incident between R22 and R76 revealed the following: .Witnesses: CNA 'P' . Witnesses: Avion [NAME] .Investigation Summary .Incident Details: On 11/3/2025 at approximately 3:45pm the facility was notified of an allegation involving physical contact initiated by (R22) toward (R76). (R76) had a fall from the wheelchair related to the incident. The incident occurred in the dining room with one staff member present. Staff Witness Statement Summary: (R76) had just returned from (an outside appointment). She was placed by the window in the dining room. As she was being assisted, (R22) approached her from behind making physical contact that resulted in (R75) falling from the wheelchair . The statement was handwritten by the Director of Nursing (DON) and signed by CNA 'P'. On 2/10/26 at 10:08 AM, an interview was conducted with CNA 'P' via the telephone regarding the incident between R22 and R76 on 11/3/25. When queried about what happened, CNA 'P' explained R76 returned from an outside appointment in the afternoon and although she was not R76's assigned CNA that day, she brought R76 back up to the unit when she returned, took her coat off, placed her near the window in the dining room because she was warm, and got her situated. CNA 'P' was opening the window when R22, who was previously on the other side of the dining room, appeared by R76. R22 Grabbed her out of the chair by her shirt and would not let go. CNA 'P' said R76 fell out of the wheelchair onto the floor and R22, who was only able to use one arm, continued swinging at R76. CNA 'P' reported a nurse (Registered Nurse - RN 'Q') came into the dining room while it was happening and assisted CNA 'P' to separate the residents. CNA 'P' said she gave all of the details to the DON, she wrote them down, and then CNA 'P' signed off on the statement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/10/26 at 10:20 AM, an interview with RN 'Q' was attempted via the telephone. RN 'Q' was not available for interview prior to the end of the survey. On 2/9/26 at approximately 10:00 AM, R76 was not in her room. At 1:14 PM, R76 was not in her room. Staff said she was at an outside appointment. On 2/10/26 at 9:19 AM, R76 was observed in the dining room, sleeping in a wheelchair. Was unable to interview R76 at that time. A review of R76's clinical record revealed R76 was admitted on [DATE] with diagnoses that included Lupus, anxiety disorder, major depressive disorder, auditory hallucinations, cerebral palsy, and legal blindness. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R76 had moderately impaired cognition. On 2/9/25 at 1:09 PM, R22 was observed in his room eating lunch. When spoken to, R22 did not make eye contact or respond verbally. On 2/10/26 at 9:17 AM, R22 was observed in the dining room, making grunting noises and watching television. R22 was unable to be interviewed. A review of R22's clinical record revealed R22 was admitted into the facility on 5/6/22 with diagnoses that included: brain injury and epilepsy. A review of an MDS assessment dated [DATE] revealed R22 had severely impaired cognition. On 2/11/26 at 8:55 AM, an interview was conducted with the Administrator who was the Abuse Coordinator for the facility. When queried about why only physical contact was reported to the State Agency and not exactly what happened according to the witness (CNA 'P') and what was documented in the clinical record, the Administrator reported she understood it should have more detail to explain what actually happened. R96 On 2/10/26 at 1:30 PM, a review of facility provided, Concern Form dated 8/4/25 reported from R96 was conducted and read, Describe concern using factual terms: Resident alleges when call light is pressed staff turn of {sic} call light from desk without completing the task .[NAME] taken regarding concern: Verbal statement from nurse during Admin (Administrator) investigation: Nurse admitted to turning off call light without addressing issues. Staff educated on call light response .Nurse provided one-on-one . On 2/11/26 at 12:15 PM, an interview was conducted with the facility's Administrator regarding R96's concern form. They were asked if they recalled the incident and to identify the nurse that admitted to turning off R96's call light without tending to their needs/request. The Administrator indicated they remembered the incident and identified Nurse 'O'; who admitted to turning off the call light from the nursing station without going to check why R96 activated the call light. They were then asked if they reported R96's documented allegation of Nurse 'O' neglecting to answer their call light and turning it off from the nursing station and said they did not. On 2/11/26 at 12:36 PM, R96 was observed in their bed with a specialized, breath activated call light designed for patients with limited or no motor skills, such as quadriplegia. A that time, an interview (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was conducted with R96 regarding staff turning off the call light from the nursing station desk without tending to their needs/request and reported staff were still doing it. When they were asked how they knew the call light was deactivated from the nursing desk they explained that when the light is activated a bell sounds in the hallway, and when the bell stops sounding, and no one comes to their room the light was deactivated from the nursing station. A review of R96's clinical record revealed they admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnoses that included: quadriplegia, peripheral vascular disease, chronic pain, pressure ulcers, neuromuscular dysfunction of the bladder, presence of a suprapubic catheter, and urinary tract infections. A review of a facility provided policy titled, Abuse updated 5/2023 was conducted and read, .Initial Reporting: The facility will ensure that all allegations involving abuse, neglect, exploitation .are reported immediately to the Administrator and: Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to thoroughly investigate an allegation of mistreatment for one (R28) of five residents reviewed for abuse/neglect. Findings include:On 2/9/26 at 9:32 AM, R28 was observed in their motorized wheelchair entering their room. When interviewed, R28 said an aide entered their room in May of 2025 and stated they were going to get R28 up. R28 stated they were telling the aide how to properly transfer them and the aide said they were getting R28 up however they (the staff member) wanted to get them up. R28 stated the aide then proceeded to transfer them into the sit to stand machine and left them strapped to the machine hanging while the aide changed the resident's brief while they were in the standing position. R28 explained the position they were left in for that extended period of time have caused them pain they still endure from the incident. R28 stated they had called the police over the incident, however, they were denied the opportunity to file charges with the police. R28 stated the Administrator told them they would handle it internally.A review of the medical record revealed R28 was admitted to the facility on [DATE] with diagnoses that included quadriplegia and required staff assistance for all Activities of Daily Living (ADLs).On 2/20/26 at 12:39 PM, the Administrator was asked to provide all grievances and Incident and Accident reports for R28 from May 2025 to current. One concern form was provided by the Administrator which was not associated with the concern R28 verbalized.Review of the medical record revealed no documentation of the incident to have been identified or to have occurred.On 2/10/26 at 2:00 PM, the Therapy Director (TD) I was asked to provide therapy notes and/or evaluations for the resident during the time frame of May 2025.A review of an Occupational Therapy Discharge summary dated [DATE] to 6/11/25, that documented in part . Resident reporting concerns including discomfort and limited ability to optimize standing with use of some slings and various staff members. expressing concerns related to EZ stand lift transfers. Direct care staff in need of education related to utilization of EZ stand and specific needs of resident. TD I was interviewed and asked about the documented concerns with the various staff members and asked if they remember the names of the staff and TD I stated they did not.On 2/10/26 at 3:19 PM, an interview was conducted with the Administrator. The Administrator was asked about the incident regarding the reported concern of mistreatment and improper transfer for R28. The Administrator denied having any knowledge of an incident to have occurred. At this time, it was confirmed with the Administrator that R28 had no Incident and Accident reports on file and one concern form from May 2025 to current and the Administrator confirmed.On 2/11/26 at 10:26 AM, an interview was conducted with Certified Nursing Assistant (CNA) J (a CNA mentioned by R28 to have been involved in the incident) was interviewed via telephone and asked about the transfer of R28. CNA J stated it was not them. CNA J stated they remember this incident occurred over Memorial day weekend and came in the next day and was told not to go into R28's room because of an allegation. CNA J stated a month later they were contacted by the Administrator via telephone and was told they were suspended because R28 called the police to report an allegation on CNA J. CNA J stated during this same phone call the schedule was reviewed and it was confirmed that CNA J was not assigned to the resident on the weekend the incident occurred. CNA J stated they were told they can return back to work before the phone call ended with the Administrator. CNA J stated they remember a young CNA to have been identified as the aide that was assigned to R28, however the aide had worked at the facility for maybe a month and was no longer employed at the facility.A review of the assignment sheets for the Memorial day weekend of 2025 was conducted. There was seven identified CNAs scheduled that weekend that was no longer employed by the facility. The personnel files that included the documentation for discontinued employment with the facility was requested from the Administrator on 2/11/26 at 11:46 AM.On 2/11/26 at 12:14 PM, the Administrator provided six of the personnel files requested and there was no documentation contained in any of the personnel files on why either CNA (continued on next page)

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The Lakeland Center	26900 Franklin Road Southfield, MI 48034

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no longer employed at the facility. The Administrator was asked to provide the missing personnel file and the documentation for discontinued employment for all of the seven CNAs. The requested information was not provided by the end of the survey.On 2/11/26 at 12:30 PM, the former Director of Nursing (DON) (who was the DON at the time of the incident) was interviewed and asked about the reported transfer incident with R28. The DON stated they remembered a hoyer incident to have occurred with R28 but vaguely remembered the details.On 2/11/26 at 2:35 PM, the Administrator was interviewed and asked about the police to have been called by R28 regarding the incident of mistreatment and asked about the telephone interview with CNA J to have been suspended due to the start of the investigation for the concern reported by R28. The Administrator stated they could not remember the incident and had no documentation of the incident to provide.A review of a facility policy titled Abuse updated 5/24/23, documented in part . Residents have the right to be free from. mistreatment. It is the Center's policy to investigate all alleged violations involving Abuse, Neglect. Mistreatment. Prevent further. mistreatment while the investigation is in progress. The investigation process includes. Determining the purpose of the investigation and issue(s) to be investigated, whether or not the alleged violation has occurred, the extent, and cause. Identifying and interviewing all involved persons. providing complete and thorough documentation of the investigation.No further explanation or documentation was provided by the end of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2603176 and 2610478.Based on observation, interview and record review, the facility failed to implement interventions per plan of care following a resident to resident incident (between R51 and R16) for one (R51) of six residents reviewed for accidents. Findings include:Review of a complaint reported to the State Agency on 9/9/25 documented R51 reported an incident from 9/8/25 in which another resident (R16) came into their room with just a brief on and scared her.Review of the clinical record revealed R51 was initially admitted into the facility on 5/19/21, readmitted on [DATE] with diagnoses that included: generalized anxiety disorder, major depressive disorder recurrent moderate, adjustment disorder, other osteochondrodysplasia with defects of growth of tubular bones and spine, short stature due to endocrine disorder unspecified, and neuralgia and neuritis.According to the Minimum Data Set (MDS) assessment dated [DATE], R51 had intact cognition.Review of the care plans included, The resident expressed desire for enhanced safety and privacy measures in her room. This care and interventions had been initiated on 9/22/25 by Former MDS Coordinator (Nurse ?D') and had not been discontinued as of this survey.Interventions included:Place a red stop sign on the resident's door as a visual cue to discourage uninvited entry.Reinforce the residents' rights to privacy and safety.Observations during the survey on 2/9/26 at 12:39 PM, 2/10/26 at 8:50 AM, and 2/10/26 3:17 PM revealed there was no placement of any Velcro stop signs within R51's doorway. Throughout the survey, R16 was observed lying in bed in their room which was located directly across from R51's room.On 2/11/26 at 8:35 AM, an interview was conducted with Certified Nursing Assistant (CNA ?F') who was assigned to R51. When asked about whether they were aware there should be a Velcro stop sign for R51's room, according to the care plan, CNA ?F' reported they had worked at the facility for a year and had never seen anything like that for R51.On 2/11/26 at 8:43 AM, an interview was conducted with the Director of Nursing (DON). When asked to review R51's care plan following the concern from 9/8/25, the DON reported that was prior to their employment which began in October 2025 and was unable to offer any explanation, but reported if that was an intervention it should've been in place for R51. The DON further reported Nurse ?D' no longer worked at this facility. When asked if the facility had Velcro stop signs to utilize, the DON reported they definitely did and they just saw one at the nursing station today.According to the facility's policy titled, Care Plan - Comprehensive and Revision dated 2/2/2026: .Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to .Receive the services and/or items included in the plan .

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. This citation pertains to intakes 2615522, 2645363, and 2671721. Based on interview and record review, the facility failed to ensure that one of five Certified Nursing Assistants (CNA ?AA') whose in-service training files were reviewed, had the required 12 hours of in-service training within the required time period. Findings include:On 2/11/26 at 8:06 AM, the facility was requested via email to provide the CNA (Certified Nursing Assistant) inservice/education training hours for five CNAs (Y, Z, AA, BB, and CC).Review of the documentation provided by the facility revealed CNA ?AA' only had 7.75 hours of education from 2024.On 2/11/26 at 12:45 PM, an interview was conducted with the Infection Preventionist / Staff Development (Nurse ?C'). They reported they had been in their role as Staff Development since mid-October (2025). When asked about the facility's process for ensuring annual education in-services were completed, Nurse ?C' reported they did reconcile of the hours and was not sure if the electronic system was glitching or not, but the documentation provided was what they were able to find.When asked about whether they received any assistance since they also performed the role as the Infection Preventionist, Nurse ?C' reported there was corporate oversight but was unable to offer any further explanation as to why the facility had not identified CNA ?AA's lack of education/training. They were requested if there was any additional documentation, they could provide by the survey exit but there was no additional documentation provided.According to the facility policy titled, In-Service Tracking dated 2/4/2024: .Each Center Administrator will appoint a Staff Development Nurse or Human Resources Representative to be responsible for tracking in-service education.The department manager will assure timely student in-service education completion.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to adequately assess one (R22) of one resident reviewed for social services to ensure they received appropriate medically related social services. Findings include: A review of R22's clinical record revealed R22 was admitted into the facility on 5/6/22 with diagnoses that included: hemiplegia right dominant side, motor vehicle accident injury, hypothyroidism, aphasia (difficulty speaking), dysphagia (difficulty swallowing), epilepsy, brain injury, depression, and anxiety. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R22 had severely impaired cognition. A review of R22's annual and quarterly Social Services Assessments revealed the last assessment was completed on 5/6/22. A review of R22's quarterly assessment progress notes revealed the last note was documented in 2023. On 2/11/26 at 9:04 AM, an interview was conducted with the Social Services Director (Social Worker - SW 'B'). When queried about when residents were assessed for medically related social services, SW 'B' reported a full social services assessment was completed on admission, readmission, if there was a change in condition, and quarterly. SW 'B' explained the assessment was documented on the Social Services Assessment Form. At that time, R22's clinical record was reviewed with SW 'B' and the lack of assessment was discussed. SW'B reported he would look into it. On 2/11/26 at 9:19 AM, SW 'B' followed up and reported R22 was not assessed since 2022. On 2/11/26 at approximately 9:30 AM, an interview was conducted with the Administrator who said there should have been an assessment done quarterly. A facility policy regarding social service assessments was requested. However, only a policy regarding admission assessments was provided by the end of the survey.

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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. Based on interview and record reviews the facility failed to ensure documentation of the resident/resident representative to have been offered the Influenza vaccine annually (R72) and ensure documentation of education to have been provided to the resident and/or resident representative for the Influenza immunization for two (R's 72 & 23) of five residents reviewed for Immunizations. Findings include:R72A review of R72's medical record and immunization profile noted the family to have refused the Influenza vaccine on 10/01/2021. This was the only documentation of the Influenza vaccine on the profile.Further review of the medical record documented the resident as their own responsible party.There was no documentation of the resident/resident representative to have been educated and offered the Influenza vaccine since 2021.R23A review of R23's medical record and immunization profile noted on 12/23/25 the resident refused the Influenza vaccine.Further review of the resident's medical record noted the granddaughter to be the resident's responsible party and power of attorney for care. There was no documentation of the granddaughter to have been provided education or provided the option to have R23 vaccinated.The facility's Administration team was asked to provide the facility's Influenza and Pneumococcal policies and procedures upon entrance, however, was not provided for review.On 2/11/26 at 11:06 AM, the facility's Infection Preventionist (IP) C was interviewed and asked the facility's process on ensuring all residents/resident representatives are educated and offered the Influenza vaccinations annually and IP C stated they pull the immunization reports for all new admissions and offer it to the resident if it is due. IP C stated they offer it to the residents that reside in the facility annually. IP C was then asked about R72 and why they had not been educated and offered the Influenza vaccination since 2021. IP C looked into their system and stated they would look into it and follow back up. IP C was then asked about providing education and obtaining consent from the correct resident representative and/or resident if they are their own responsible party. IP C stated they review the medical record to see if a guardian is appointed and educate and obtain the guardian consent or refusal. IP C was then asked about R23, who their responsible party was and if the correct party was provided education and offered the vaccination. IP C stated they would look into it and follow back up. IP C was asked about the education they provided to the residents and/or resident representative regarding the Influenza vaccine and asked to provide it for review. IP C stated they would look into it and follow back up.On 2/11/26 at 12:59 PM, the facility team uploaded the Centers for disease and control prevention education sheet into the survey egress system. No further explanation or documentation was provided by the end of the survey.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. This citation pertains to intakes 2615522, 2645363, and 2671721. Based on interview and record review, the facility failed to ensure that two of five Certified Nursing Assistants (CNAs ?AA' and ?CC') reviewed for required annual in-service education, had the required 12 hours of in-service training within the required time period which included abuse prevention and dementia care. Findings include:On 2/11/26 at 8:06 AM, the facility was requested via email to provide the CNA (Certified Nursing Assistant) inservice/education training hours for five CNAs (Y, Z, AA, BB, and CC).Review of the documentation provided by the facility revealed:CNA ?AA' last had abuse and dementia care education on 2/20/24.CNA ?CC' had no dementia care education.On 2/11/26 at 12:45 PM, an interview was conducted with the Infection Preventionist / Staff Development (Nurse ?C'). They reported they had been in their role as Staff Development since mid October (2025). When asked about the facility's process for ensuring annual education in-services were completed and included all the required components including abuse and dementia care, Nurse ?C' reported they did reconcile of the hours and was not sure if the electronic system was glitching or not, but the documentation provided was what they were able to find.When asked about whether they received any assistance since they also performed the role as the Infection Preventionist, Nurse ?C' reported there was corporate oversight but was unable to offer any further explanation as to why the facility had not identified CNA ?AA's lack of education/training. They were requested if there was any additional documentation, they could provide by the survey exit but there was no additional documentation provided.According to the facility policy titled, In-Service Tracking dated 2/4/2024: .Each Center Administrator will appoint a Staff Development Nurse or Human Resources Representative to be responsible for tracking in-service education.The department manager will assure timely student in-service education completion.