STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235594	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Niles	1211 State Line Rd Niles, MI 49120

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2715364.Based on interview and record review, the facility failed to provide quality wound care to promote healing and prevent the deterioration of a pressure ulcer for 1 (Resident #121) of 3 residents reviewed for wound care resulting in an Immediate Jeopardy when on 1/8/26, Resident #121 was hospitalized with altered mental status and septic shock (life-threatening condition caused by a severe infection) from a necrotic (death of cells in tissue) sacral ulcer (pressure ulcer at the base of the spine) with osteomyelitis (infection in a bone) requiring surgical intervention and bone debridement. Findings include: Resident #121 The Immediate Jeopardy began on 12/26/25 when Resident #121 was unable to have his pressure ulcer cared for per orders and was not completed by nursing staff and was subsequently hospitalized with altered mental status and septic shock from necrotic (dead tissue) sacral ulcer with osteomyelitis requiring surgical intervention and bone debridement. Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy verbally and via email on 2/5/26 at 4:40 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on 2/5/26, but noncompliance remains at scope of isolated and severity of actual harm due to sustained compliance that has not been verified by the State Agency. Review of an admission Record revealed Resident #121 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcer of sacral region stage 4, and need for assistance with personal care. Review of Resident #121's Hospital Discharge summary dated [DATE] revealed, .Hospital Course: further examination revealed multiple deep ulcerated decubitus ulcers (pressure ulcer) and elevated CRP (lab test measures the level of C-reactive protein in your blood, indicating inflammation in the body and helping diagnose various conditions) at 8 concerning for osteomyelitis. CT (computed tomography) were reviewed . CT pelvis showed deep sacral decubitus ulcers without CT evidence of osteomyelitis . During the course of hospital stay: Patient was evaluated by surgery team, underwent debridement (medical process of removing dead, damaged, or infected tissue from a wound to promote healing and prevent infection) of the wound, clean borders achieved. Wound vac (device that uses gentle suction to promote faster and more effective wound healing), ID (Infectious Disease) recommend total of 7 days of antibiotics . He (Resident #121) is comfortable going to SNF (skilled nursing facility) with a goal for better wound care . Discharge Planning . Pressure injury, Wound clinic in 2 weeks 1/1/26 (wound care provider) in 2 weeks . Review of Resident #121's Clinical Discharge summary dated [DATE] revealed, . Follow up: Wound Clinic. When: In 2 weeks. 1/1/26 . Review of Resident #121's Documentation of Symptoms for Sacral wound indicated findings of increased drainage on the following dates: 12/29/25, 12/30/25, 12/31/25, 1/3/26, 1/4/26, and 1/8/26, findings for foul order on the following dates: 12/29/25, 12/30/25, 12/31/25, 1/3/26, 1/4/26, and 1/8/26, findings for Surrounding warmth on the following dates: 12/31/25, 1/3/26, 1/4/26, 1/8/26 and 1/8/26 and findings for Surrounding edema (swelling) on 12/31/25, 1/3/26, 1/4/26, and 1/8/26 . Review of Resident #121's Progress Note dated 1/8/26 revealed, (Resident #121) is being sent to the ER for further evaluation of altered mental status and ? infection (sic). Order received from NP MMM to send patient to the ER . Review of Resident #121's Hospital Records dated 1/8/26 revealed, . ED Course: . presents by EMS (Emergency Medical (continued on next page)

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

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Services) for altered mental status and concern of worsening sacral wound. Per EMS, the patient is typically A&O (alert and oriented) x4 and is able to ambulate. Over the last few days patient has reportedly been more disoriented and not ambulating by himself. EMS reports that worsening facility nurses were concerned about sacral wound worsening. Reportedly SNF (Skilled Nursing Facility) nurses were concerned that sacral wound was worsening .Examination of sacral wound shows wound with VAC in place. There appears to be erythema surrounding wound with fluctuance (boggy sensation felt on palpitation, indicating a fluid filled area) present . Purulence (pus that is produced in infected tissue) noted near the tailbone . Hospital Course: . Septic shock from necrotic sacral ulcer with osteomyelitis, Bacteroides and gram positive bacilli bacteremia (presence of bacteria in the bloodstream), Pseudomonal UTI (urinary tract infection). s/p (status post) incision and drainage of sacral wound 01/09, bone biopsy shows osteomyelitis. ID (Infectious Disease) consulted . Wound Care Consult Note 1/9/26: 2. Coccyx/sacral wound 10.5 x 11 (Centimeters) x unable to assess due to necrotic tissue with bone exposed and palpable wound connect under necrotic tissue. Undermining circumferential in varies depth to uncomfortable for patient to obtain measurement. Peri wound skin erythema/nonblanchable /odor noted. Right lower leg lateral 7.6 CM x 3.9 (centimeters)x tissue purplish/black. Right anterior lower leg 3.5 x 1.1 (centimeters) x necrotic. Left lateral ankle 8 x 4 (centimeters) x Deep tissue injury Assessment: . 2. Unstageable pressure ulcer coccyx/sacral. 3. Right lower leg lateral unstageable pressure injury versus Deep tissue injury 4. Right anterior lower leg unstageable pressure injury 5. Left lateral ankle appears to be deep tissue injury evolving 6. Skin tear left arm . Infectious Disease Consultation 1/14/26: . On 01/09/2026 patient had incision and drainage and debridement of the sacral wound with bone biopsy taken that is showing acute osteomyelitis . During an interview on 2/04/2026 at 1:23 PM, Family Member (FM) FFF reported Resident #121 had been admitted to the facility on [DATE] after being hospitalized due to his coccyx wound. FM FFF reported that Resident #121 had admitted to the facility to continue receiving wound care treatments. FM FFF reported Resident #121 was typically alert and oriented, and able to ambulate in his wheelchair. FM FFF reported she first noticed that something seemed to be wrong with Resident #121 during a care conference at the facility on 12/24/25 when she noted that Resident #121 seemed to be noticeably more confused. FM FFF reported she had voiced her concern that Resident #121 seemed more confused than usual and was told that staff would get back with her regarding her concern. FM FFF reported on 12/26/25 she found Resident #121 lying in his room and that he appeared very pale and ill. FM FFF reported the nurse caring for Resident #121 had informed her that Resident #121 had not had his sacrum dressing changed because the facility was waiting on supplies to come in. FM FFF reported that she continued to voice concerns about Resident #121 condition at this time, and she felt that she felt that staff were not taking her concerns seriously. FM FFF reported she was called by LPN TT on 12/29/25 and told that Resident #121's wound looked worse, and that she was waiting for the wound doctor to look at it before putting the wound vac back on. FM FFF reported that she did not hear back from the facility about Resident #121's condition after she had talked with LPN TT on 12/29/25. FM FFF reported she went to visit Resident on 1/5/26 and noted that Resident #121 could hardly talk and seemed confused or sedated. FM FFF reported that she spoke with the nurse caring for Resident #121 and expressed her concerns that Resident #121 was declining, FM FFF reported that staff reported that they would look into it again. FM FFF reported that she called the facility's Social Worker (SW) on 1/6/26 to discuss her concerns that Resident #121 was declining, and that she received a call back from on 1/7/26 from SW XX that the facility had a call into the doctor at the facility to see Resident #121. FM FFF reported that the next day, 1/8/26, Resident #121 was transported to the emergency room where he was admitted to the hospital. FM FFF reported that Resident #121 was transferred to the Intensive Care Unit (ICU) and had to have surgery the following day on his sacrum wound. FM FFF reported that she had spoken with the facility's Nursing Home Administrator (NHA) A on 1/9/26 and expressed her concerns about Resident #121's health decline and the facility response. FM FFF' reported that she was told the (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility was investigating her concerns. FM FFF reported that she received a follow up call from Clinical Support Nurse (CSN) AAA where she was informed that the facility had not provided care for Resident #121's that was up to the facility standards, and that the facility was investigating her concerns. FM FFF reported that she never heard back from the facility staff after her call with CSN AAA. During an interview on 2/05/2026 at 11:34 AM, Certified Nursing Assistant (CNA) P reported she cared for Resident #121 often. CNA P reported that when Resident #121 first came to the facility he was alert, very kind, and required assistance of 1 staff member for ADL (Activities of daily living care) and then he seemed to go downhill all of a sudden. CNA P reported that Resident #121 became combative and he became unable to feed himself. CNA P reported that it seemed like she noticed the change in Resident #121 began when the facility took his wound vac off. CNA P was not aware of the date that the facility had removed Resident #121's wound vac. During an interview on 2/05/2026 12:41 PM, CNA S reported she had cared for Resident #121 and was familiar with him. CNA S reported Resident #121 did seem to quickly decline after he was admitted to the facility. CNA S reported Resident #121 began to require more assistance, seemed more confused and was getting more combative. During an interview on 2/05/2026 at 11:40 AM, LPN TT reported that she had cared for Resident #121 multiple times since he had been admitted to the facility. LPN TT' reported Resident #121 had declined after he was admitted to the facility, and Resident #121's family member had expressed concerns related to his decline. LPN TT reported she thought that the nurses had told NP MMM about Resident #121's decline, but she was not sure what NP MMM did for Resident #121. LPN TT reported on 12/26/25 she was unable to complete Resident #121's dressing change to his sacral wound because the facility did not have the wound vac supplies. LPN TT reported she passed along to the oncoming nurse that the nurses would need to complete a wet to dry dressing change and remove Resident #121's wound vac that night if the supplies did not arrive. LPN TT reported that when she returned to the facility on [DATE], Resident #121's wound vac was still on, and the facility did not have supplies, so she was not able to confirm if the facility had changed Resident #121's dressing since 12/26/25. LPN TT reported that on 12/29/25, as she changed Resident #121's wound vac, she observed bone in Resident #121's sacral wound, and that the wound was black and the tissue was necrotizing. LPN TT reported that the wound appeared to be worsening LPN TT reported that she asked for Former Director of Nursing (F-DON) UU and LPN NN to assist her to provide treatment to Resident #121's wound. LPN TT reported that she was instructed F-DON UU to remove Resident #121's wound vac, apply a wet to dry dressing, and contact Resident #121's wound clinic. LPN TT reported that she tried to find what wound clinic Resident #121 had gone to, but she was unsuccessful. LPN TT reported that when Resident #121 was sent to the hospital on 1/8/26 she had found a wound on his right leg that she did not know was even there, and she did not think that facility had treatment orders in place for Resident #121's leg wound. During an interview on 2/05/2026 at 11:57 AM, LPN PP reported that he had cared for Resident #121, and that he recalled that Resident #121 seemed to need more assistance with care after he was admitted to the facility. LPN PP reported that he had completed wound care on 1/7/26, he had noticed that Resident #121's wound did not seem to be improving, and that there were brownish slough (dead tissue) spots across the wound. LPN PP reported that he thought that there was some issue with Resident #121's wound vac, so the facility had removed the wound vac and completed wet to dry dressings for a while, but he was not able to confirm the date that Resident #121's wound vac was removed or placed back on. When this writer queried LPN PP about Resident #121's TAR documentation on 12/21/25, where LPN PP had documented a . under the note for if Resident #121's wound care treatment had been complete, LPN PP reported that he did not know why he did not document whether the treatment was completed or not, and that he should have documented more than a period. LPN PP confirmed that his documentation did not indicate whether he had completed Resident #121's wound care treatment, and that he could not recall if he had missed any of Resident #121's wound care treatments. LPN PP reported that he could not recall if had notified the facility's provider that Resident #121's wound was (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	worsening. During an interview on 2/05/2026 at 4:12 PM, LPN NNN reported she had cared for Resident #121 and recalled that Resident #121's wound care treatments were scheduled to completed on first shift. This writer queried about LPN NNN's documentation for Resident #121 on 12/31/25 which stated, No wound care this shift. LPN NNN reported she had documented that to remove the task from her list, and to confirm that she did not complete Resident #121's wound care treatment on that shift. LPN NNN confirmed that she had passed that information along to the oncoming nurse, but there was no way to verify if Resident #121's wound care treatment had been completed. LPN NNN reported it was common for her to skip treatments when she worked at the facility because she was struggling to manage the workload. During an interview on 2/05/2026 at 4:27 PM, LPN SS reported she was the nurse that had admitted Resident #121. LPN SS reported that Resident #121 was not admitted with his wound vac on, and she was not sure when the facility had gotten his wound vac. LPN SS reported she recalled documenting Resident #121's wounds but could not recall if she measured them or what any of his wounds looked like. LPN SS reported the admitting nurse places orders based on the hospital discharge paperwork, which is where she found the order for Resident #121's wound vac treatment. LPN SS did not recall if Resident #121 had an appointment scheduled with a wound clinic. LPN SS confirmed that she had been told by LPN TT on 12/26/25 that if the supplies did not come in for Resident #121's wound vac treatment, she would need to complete a wet to dry dressing change. LPN SS reported that on 12/26/25 during Resident #121's wound care treatment she noted that the wound looked much worse than when Resident #121 was first admitted , and it was bigger in size. LPN SS reported that there were several areas where the tissue on the wound was black. LPN SS reported she had noticed that Resident #121 had seemed to have declined, and that Resident #121's family member had also voiced concerns about his decline. LPN SS reported that Resident #121 was more confused and needed more assistance than when he was first admitted . LPN SS reported that she thought she had a left a note in the provider book for NP MMM, but she could not recall when. During an interview on 2/05/2026 at 1:06 PM, Clinical Care Coordinator (CCC) CC reported Resident #121 was admitted with a wound vac on his sacral wound, and that the dressing was supposed to be changed three times a week. CCC CC reported that she did not think that the facility was aware that Resident #121 was supposed to follow up with a wound clinic on 1/1/26. CCC CC reported that the facility submitted a referral to a wound clinic for Resident #121 on 12/31/25, and that he was scheduled for 1/14/26. CCC CC confirmed that she was aware that staff and Resident #121's family had expressed concerns that he was declining, and that she thought that NP MM was aware. CCC CC reported that she was on vacation from 12/27/25- 1/5/26, and when she returned from vacation, she discovered that two of the facility nurses had put in an order for Resident #121's sacral wound care order to be changed to a wet to dry dressing. CCC CC reported that she did not know who had given the order for the nurses to change Resident #121's wound care orders, so she instructed LPN PP to place the wound vac back on Resident #121. CCC CC reported that she did not know why the facility nurses were documenting that the facility was out of wound care supplies, because the facility was never out of supplies, and that they were in the storage room. CCC CC reviewed Resident #121's TAR with this writer and confirmed that Resident #121 had several missing and inaccurate documentation for wound care treatments. CCC CC reported that if a nurse marks a treatment as hold- see note, the nurse should document the reason the treatment was missed. CCC CC reported Medical Records (MR) ZZ would have been responsible for arranging appointments for Resident #121. During an interview on 2/05/2026 at 1:27, MR ZZ reported that she was responsible for reviewing the hospital discharge orders for residents to arrange transportation/scheduling for residents. MR ZZ reviewed Resident #121's hospital records with this writer and confirmed that she was not aware that Resident #121 was supposed to follow up with a wound clinic on 1/1/26, and that she had missed this, therefore Resident #121 had not gone to the wound clinic during his admission at the facility. During an interview on 2/05/2026 at 1:39 PM, NP MMM reported she had been made aware that nursing staff at the facility were concerned about the presence of bone on Resident #121's (continued on next page)

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	affected area topically every day and evening shift for wound. Discontinued: 1/7/26. Noted that this order did not identify which wound this treatment was indicated for.Review of Resident #121's TAR revealed, Wound location: left hip ulcer; cleanse with NS, pat dry with gauze, apply boarder foam dressing every day shift. Discontinued date 12/27/25. Noted that the treatment had not been documented to indicate if the treatment was completed or missed on 12/22/25. On 12/21/25 and 12/25/25 the TAR treatment was documented as See progress note. Review of Resident #121's TAR revealed, Wound location: Right posterior ribs, Open area x2 cleanse with NS, pat dry with gauze, apply boarder form every shift. Noted that it the treatment was not documented as completed or missed on 12/30/25 and see progress note on 12/31/25. Noted that there were no treatments orders for the right ankle or left ankle or right leg in Resident #121's TAR. Review of Resident #121's Progress notes dated 12/21/25 and 12/25/25 revealed Orders: administration note: . Noted that the nurse only documented a . (period) in the progress note and did not indicate why the treatment was missed/held. Review of Resident #121's Progress note dated 12/26/25 revealed, Orders administration record: Awaiting wound vac supplies.Review of Resident #121's Progress Note dated 12/29/25 revealed, This author attempted to change wound vac dressing today. Supplies have not arrived . Review of Resident #121's Progress Note dated 12/29/25 and documented by Licensed Practical Nurse (LPN) TT revealed, LPN attempted to change wound vac dressing. Dressing removed. LPN observed wound down to bone in right buttock wound. Left buttock wound does have some tissue left. Tissue between both wounds is necrotizing. Peri wound is red, hot to touch. DON (Former Director of Nursing) UU aware. Instructed to wet to dry (applying moist gauze to a wound, followed by dry gauze, then allowing it to dry completely and stick to dead tissue so that when it is removed the dead tissue comes with it) and call wound clinic. Wound clinic called, LPN left message on nurse line at (number redacted) for further instruction. Awaiting call back. Family aware . Review of Resident #121's Progress Note dated 12/29/25 and documented by LPN TT revealed, (wound care provider) does not see (Resident #121) for wound vac. LPN left message with Nurse Practitioner (NP) MMM for further instructions. Review of Resident #121's Progress Note dated 12/30/25 revealed, Resident recently declined, NP MMM consulted. labs to be obtained STAT .Review of Resident #121's Progress Note dated 12/30/25 revealed, Treatment completed and resident with little resistance. some drainage noted to old dressing with some odor to it .Review of Resident #121's Wound Measurements dated 12/31/25 revealed, .Observations: Site: Right buttock: Length: 6 CM. Width: 3.6 CM. Depth: 1.3 CM. Stage: IV. Site: Sacrum. Length: 8.3 CM. Width: 3.9 CM. Depth: 2 CM. Stage: IV . The documentation indicated the wound on Resident #121's Right buttock had Granulation (is reddish connective tissue that forms on the surface of a wound when the wound is healing- firm/red, moist, pebbled healthy tissue and Slough (dead tissue)- dry/or wet, loose or firmly attached, yellow to brown dead tissue present with moderate amounts of Serous- (thin, yellowish fluid) and Sanguineous (bloody fluid). The wound had a presence of odor, and the wound edges were presented as rolled (curled under). Tunneling (a narrow passageway or tunnel extending from the wound, usually in one direction) or undermining (damage that extends beneath the wound edges in multiple directions, creating pockets or shelves beneath the skin) was also noted. Review of Resident #121S Progress Note dated 12/31/25 revealed, .Wound vac remains on hold until further wound care evaluation completed. Wound is larger, with necrotizing tissue in the middle and bone exposure observed. Wet to dry dressing maintained at this time.Review of Resident #121's Progress Note dated 12/31/25 and documented by LPN NNN revealed, No wound care this shift. Review of Resident #121's Progress Note dated 12/31/25 and documented by NP MMM revealed, Infected decubitus ulcer-Completed Augmentin and Bactrim (antibiotics) for total of 7 days. Continue wound vac, follow up with wound clinic on 1/14 .Review of Resident #121's Progress Note dated 1/6/26 revealed, . Wound care completed to buttocks, wet to dry. Wound drainage green/yellow, odor increased. Tenderness increased. Not able to participate in therapies at this time .Review of Resident #121's Wound Measurements dated 1/7/26 revealed, .Observations: Site: [TRUNCATED]

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure annual performance evaluations for certified nursing assistants were completed, resulting in the potential for the delivery of nursing and related services that does not support or maintain the residents highest practicable physical, mental, and psychosocial well-being.Findings include: Based on interview and record review, the facility failed to ensure annual performance evaluations for certified nursing assistants were completed, resulting in the potential for the delivery of nursing and related services that does not support or maintain the residents highest practicable physical, mental, and psychosocial well-being.Findings include: Review of The Essentials Guide to Healthcare Performance Reviews, www.hrforhealth.com. 2024, revealed The benefits of healthcare performance reviews go beyond creating a better experience for your team .the most important [benefit) is performance reviews lead to improved performance .greater productivity and better overall experience for your patients. In an interview on 02/06/2026 at 10:32 AM, Staffing & Scheduling Manager (SSM) J reported the facility had a system the staff members were placed in upon hire at the facility and this would build the staff members permanent schedules and their talent profiles. In an interview on 02/06/2026 at 3:27 PM, Human Resources (HR) JJ reported the staff members orientation included the electronic education system and the floor competency training. HR JJ reported after orientation each staff member's orientation packet was uploaded to the system the facility used to track schedules and trainings. In an interview on 02/10/2026 at 9:38 AM, Certified Nursing Assistant (CNA) P reported she had not had an annual performance review for several years. In an interview on 02/10/2026 10:22 AM CNA W reported last week the facility had asked the CNAs to sign up for annual performance evaluations and hers was scheduled for this week Thursday. Review of CNA OOOs employee file revealed the last time an annual performance evaluation was completed was on 3/21/24. In an interview on 02/10/2026 at 11:24 AM, HR JJ reported she was unable to locate an annual performance evaluation for CNA P, but she was due next month for her annual performance evaluation. HR JJ reported her QAPI (Quality Assurance & Performance Improvement) report would indicate who was due for their evaluations and then she would send the report to the Director of Nursing (DON). Then, the DON would check off who was completed in the QAPI report and in the system used to track in the talent profile section so the next time she ran the QAPI report she would have accurate dates of completion for the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide food and drink at a palatable temperature in 2 (R32 and R72) of 22 residents reviewed for palatability among all residents. This deficient practice has the potential to result in decreased food consumption and potential nutritional decline.Findings include: Resident #32 Review of an admission Record revealed Resident # 32 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: parkinson's disease (a progressive, incurable neurodegenerative(gradual dysfunction and death of neurons in the brain) disorder of the central nervous system primarily affecting movements, causing tremors and balance issues), muscle weakness and dementia (an umbrella term for a progressive decline in cognitive function). Review of a Minimum Data Set (MDS) assessment for Resident #32 with a reference date of 1/27/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 13/15, which indicated the resident was cognitively intact. Review of a Care Plan for Resident #32 with a reference date of 1/29/25 revealed the following focus/goal/interventions: (Resident #32) is at risk for altered nutrition due to conditions associated with dysphagia (swallowing difficulty), dementia, tremor.Goal: Reduction in risk of factors for hypo-hyperglycemic events (excessively high or how blood sugar level). Interventions: Adaptive equipment: large soup spoon.serve diet as ordered. During an observation on 2/6/26 at 1:04pm, Resident #32's room lunch tray was delivered and left on his bedside table. The plate was covered with a grey, hard plastic top. During an observation and interview on 2/6/26 at 1:07pm, Resident #32 removed the top and began to eat a piece of cauliflower. Resident #32 stated the food was lukewarm at best and too tough to eat. Resident #32 then ate a bite of the loaded baked potato and stated, It's colder than the cauliflower. Resident #32 expressed dissatisfaction with the food and reported he was not going to eat. When further queried, Resident #32 reported the palatability of the food had been a concern for several months and he purchased himself nutritional drinks to ensure he could get enough calories to avoid losing weight. Resident #72 (R72) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R72 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS) reflected a score of 9 out of 15 which indicated R72's cognition was moderately impaired. During an interview on 2/04/2026 at 10:44 AM, R72 stated that her coffee was cold and it didn't matter whether she ate in the main dining room, small dining room or her room. R72 said she liked to drink hot coffee and doesn't like it cold. R72 also stated that the food was cold when she ate in her room. During an interview on 2/05/2026 at 1:12 PM, Certified Dietary Manager (CDM) III stated that she wasn't aware about coffee being cold and food on room trays being cold. CDM III stated she would start monitoring coffee temperatures and room tray temperatures. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/4/26 at 11:30 AM, an interview with Certified Dietary Manager (CDM) UUU found that lunch starts at 12:00 PM On 2/4/26 at 12:46 PM, residents in the dining room, next to the kitchen, started to get served their lunch. At this time, it was noted that no heated bases or heated plates were used during service. On 2/4/26 at 12:50 PM, an interview with CDM UUU found that food on the steam table should be 165F. On 2/4/26 at 1:09 PM, a regular test tray was plated as one of the last meals coming from the steam table. The plate consisted of two, roughly two ounce, pieces of chicken, mashed potatoes, a side salad, two peanut butter cookies, a drink, and a package of salad dressing. The test tray sat in the tray line and was picked up by the surveyor when it was its turn to be delivered. On 2/4/26 at 1:17 PM, the test tray was in the conference room with the following temperatures found using a rapid read thermometer: one piece of chicken was 140F, the other piece of chicken was 118F and the mashed potatoes were 121F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen.Findings include: On 2/4/26 at 10:46 AM, an interview with Certified Dietary Manager (CDM) UUU found that staff typically date items for a three-day discard and use the day it was made or opened to label. On 2/4/26 at 10:54 AM, observation of the two-door reach in refrigeration unit found a half empty gallon of milk dated 1/26/26. When shown to CDM UUU she discarded the product. On 2/4/26 at 10:56 AM, observation of the walk-in cooler found an open package of polish sausages with no date to indicate when the item should be discarded. On 2/4/26 at 11:57 AM, observation of the Front Street refrigeration unit found two containers of cottage cheese with best by dates of 2/2/26, an open gallon of milk with a best by date of 1/28/26, and a pitcher of thickened water dated 1/28/26. According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specifiedunder S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7days. The day of preparation shall be counted as Day 1. According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and timecombination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . On 2/4/26 at 10:53 AM, observation of the seals and gaskets on both of the four door freezers showed an increased accumulation of food crumb and black debris. On 2/4/26 at 11:12 AM, observation of the underside of the coffee unit found an increased accumulation of dried brown and black splatter debris. On 2/4/26 at 11:13 AM, observation of the ice scoop holder found an increased accumulation of brown and white crusted debris on the inside bottom of the holder. When shown to CDM UUU she took the ice scoop holder to the dish machine area. On 2/4/26 at 11:16 AM, an interview with [NAME] VVV found that the can opener had not been used today. Observation of the can opener found increased accumulation of debris on and around the blade with red staining on portions of the blade face of the unit. On 2/4/26 at 11:18 AM, an interview with CDM UUU found that the utensil drawers should get cleaned nightly by the PM cook. Observation of the mechanical scoop drawer found four scoops with stuck on food debris stored with clean utensils. Further observation of the drawer found increased accumulation of food crumb debris in the bottom. On 2/4/26 at 11:20 AM, observation of the clean utensil containers under the cookline found the containers dirty and dingy with accumulation of crumb debris inside the containers holding metal spoons, tongs, and spacers for the steam table. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 2/4/26 at 10:57 AM, observation in the walk-in cooler found a dozen sealed packages of single serve macaroni and cheese. Further review of the product found that it stated it should be kept frozen. When asked how many they go through, CDM UUU stated three or four each lunch and dinner service. On 2/4/26 at 11:38 AM, observation of the dry storage room found open containers of lemon juice and soy sauce (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sitting on a dry storage shelf. The gallon container of soy sauce was half full and the liter of lemon juice contained about 3/4 of the product. A review of both containers found their manufactures state on the label, Refrigerate After Opening. According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above. or (2) At 5C (41F) or less. On 2/4/26 at 11:28 AM, an interview with CDM UUU found that the facility did not have any chlorine test strips to test the working order of the dish machine. According to the 2022 FDA Food Code section 4-302.14 Sanitizing Solutions, Testing Devices. A test kit or other device that accurately measures the concentration in MG/L of SANITIZING solutions shall be provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to maintain complete and accurate medical records for 2 (Resident #121 and #19) of 22 residents reviewed for complete and accurate medical record documentation, resulting in the potential for staff and providers mismanaging care for residents. Findings include:Resident #121Review of an admission Record revealed Resident #121 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcer of sacral region stage 4, and need for assistance with personal care. Review of Resident #121's Treatment Administration Record (TAR) revealed, Wound Care; Sacrum: Cleanse area with NS (normal saline), Frame wound withtegaderm (type of wound dressing), loosely fill area with black foam, Cover with drape/tegaderm to secure seal. Cut quarter size hole into middle of drape and connect suction pad . Negative Pressure Wound Therapy (NPWT) to: 125mmhg Set vacuum at 125 mmHg Intermittent. Inspect settings and visualize dressing is intact every shift. every day shift. every Mon, Wed, Fri. Hold date 12/29/25-12/31/25. Noted that the treatment had not been documented to indicate if the treatment was completed or missed on 12/22/25 and 1/2/26. On 12/26/25 and 12/31/25 the TAR treatment was documented as See progress note. Review of Resident #121's Progress notes dated 12/21/25 and 12/25/25 revealed Orders: administration note: . Noted that the nurse only documented a . (period) in the progress note and did not indicate why the treatment was missed/held. Review of Resident #121's Progress Notes for 12/26/25 and 12/31/25 revealed no documentation related to the above wound care. Review of Resident #121's TAR revealed, Wound Care: R buttock with sacrum-cleanse with NS and apply wet to dry Dakins solution (wound cleanser) dressing. Change every day and PRN if dressing becomes soiled or disrupted. Everyday shift for wound management. Discontinue date: 1/10/26. It was noted that the treatment was not documented as completed or missed on 1/2/26. Review of Resident #121's TAR revealed, Wound location: left hip ulcer; cleanse with NS, pat dry with gauze, apply boarder foam dressing every day shift. Discontinued date 12/27/25. Noted that the treatment had not been documented to indicate if the treatment was completed or missed on 12/22/25. On 12/21/25 and 12/25/25 the TAR treatment was documented as See progress note. Review of Resident #121's TAR revealed, Wound location: Right posterior ribs, Open area x2 cleanse with NS, pat dry with gauze, apply boarder form every shift. Noted that it the treatment was not documented as completed or missed on 12/30/25 and see progress note on 12/31/25. Review of Resident #121's Progress Notes for 12/31/25 revealed no documentation related to the above wound care. During an interview on 2/05/2026 at 11:57 AM, this writer queried LPN PP about Resident #121's TAR documentation on 12/21/25, where LPN PP had documented a . under the note for if Resident #121's wound care treatment had been complete, LPN PP reported that he did not know why he did not document whether the treatment was completed or not, and that he should have documented more than a period. LPN PP confirmed that his documentation did not indicate whether he had completed Resident #121's wound care treatment, and that he could not recall if he had missed any of Resident #121's wound care treatments. During an interview on 2/05/2026 at 1:06 PM, Clinical Care Coordinator (CCC) CC reported Resident #121 was admitted with a wound vac on his sacral wound, and that the dressing was supposed to be changed three times a week. CCC CC reviewed Resident #121's TAR with this writer and confirmed that Resident #121 had several missing and inaccurate documentation for wound care treatments. CCC CC reported that if a nurse marks a treatment as hold- see note, the nurse should document the reason the treatment was missed. During an interview on 2/05/2026 at 2:19 PM, Clinical Support Nurse (CSN) AAA reported that she had been made aware on 1/9/26 that Resident #121's family had concerns with his care at the facility from NHA A. CSN AAA reported that she had conducted an investigation with Nursing Home Administrator (NHA) A into Resident #121's family concerns. CSN AA confirmed that the facility's nursing (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation did not indicate when or if a provider was notified about the change in Resident #121's wound and how long the wound vac was off for. CSN AA confirmed that there were several missing documented treatments for Resident #121's wounds, and that there was not an order for Resident #121's leg wound. CNS AA reported she was unaware that Resident #121 was supposed to follow up with a wound clinic on 1/1/26. Resident #19Review of an admission Record revealed Resident #19 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and major depressive disorder. Review of Resident #19's TAR revealed, WOUND CARE: Left 5th met (long bone on the outer edge of the foot that connects to the little toe) .Change 3 times a weekand as needed one time a day every Tue (Tuesday), Thu (Thursday), and Sat (Saturday) for Wound management. Noted that there was no documentation to indicate if the treatment had been completed or missed on 1/24/26 and 2/1/26. Review of Resident #19's TAR revealed, Left Great, 2nd, 3rd, 4th and 5th toe, Heel, Lateral foot and ankle . Change 3 times a week and as needed . 3 times weekly every Tue, Thu, Sat for wound care. Noted that there was no documentation to indicate if the treatment had been completed or missed on 1/24/26. Review of Resident #19's TAR revealed, Foley Cath (medical device that helps drain urine from your bladder) Care every shift for urinary retention. Empty Foley Catheter Drainage Bag Q (Every) shift & record output. Noted that there was no documentation to indicate if the treatment had been completed or missed on 1/5/26, 1/14/26, 1/15/26 and 1/25/26. During an interview on 2/10/2026 at 11:57 AM, CCC CC reviewed Resident #19's TAR with this writer and confirmed that Resident #19 was missing documentation to indicate whether his treatments had been completed or not, and that nurses were expected to complete all charting on care that residents did or did not receive.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain effective infection control practices for 6 residents (#90, #76, #32, #8, #13 and #27) of 6 sampled for infection control; as evidenced by failure to 1. Properly implement transmission-based precautions and complete testing on symptomatic residents; 2. Ensure resident shared equipment was properly cleaned; and 3. Ensure the cleanliness of a tube feeding pole/pump and the surrounding surfaces.Findings include: Review of A systematic review on the causes of the transmission and control measures of outbreaks in long-term care facilities: Back to basics of infection control. revealed The unique characteristics of long-term care facilities (LTCFs) including host factors and living conditions contribute to the spread of contagious pathogens. Control measures are essential to interrupt the transmission and to manage outbreaks effectively. This review indicates that the violation of basic infection control practice could be a major role in introducing and facilitating the spread of contagious diseases in LTCFs. It shows the need to promote compliance with basic practices of infection control to prevent outbreaks in LTCFs. https://journals.plos.org/plosone/article?id=10.1371/journal.[NAME].022991, 3/10/20. #1 Resident #90 Review of an admission Record revealed Resident #90 was originally admitted to the facility on [DATE]. In an interview on 2/4/26 at 10:00am, Nursing Home Administrator (NHA) A reported Resident #90 tested positive for Severe Acute Respiratory Syndrome Coronavirus 2 Covid 19 within the last few days. During an observation and interview on 2/4/26 at 11:24am, the signage outside Resident #90's room read Enhanced Barrier Precautions.wear gown and gloves for.high contact activities. Housekeeper (Hsk) LLL reported both Resident #90 and his roommate (Resident #76) were positive for Covid 19 infections. Resident #76 Review of an admission Record revealed Resident #76 was originally admitted to the facility on [DATE]. Review of an Interdisciplinary Progress Note for Resident #76 with a reference date of 2/3/26 revealed (Resident #76) returned to the facility at approximately 17:30 (5:30pm) .He was admitted to (name of hospital omitted) related to diagnosis of +COVID. Resident #32 Review of an admission Record revealed Resident #32 was originally admitted to the facility on [DATE]. During an observation on 2/10/26 at 9:24am, a large yellow Personal Protective Equipment (PPE) cart (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Interdisciplinary Progress Note for Resident #8 with a reference date of 2/5/26 revealed .Roommate (Resident #13) noted testing positive for COVID. Tested (Resident #8) during shift and results negative at this time. Resident #13 Review of an admission Record revealed Resident #13 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: acute on chronic respiratory failure with hypercapnia (condition in which the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). Review of a Minimum Data Set (MDS) assessment for Resident #13 with a reference date of 1/28/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. In an interview on 2/4/26 at 12:23pm, Resident #13 reported she had been ill for the past 2 days, with symptoms that included nasal congestion, fatigue and increased shortness of breath. Resident #13 reported staff were aware of her symptoms, but she had not been tested for covid. Resident #13 stated I got whatever she had. She's been sick for a week, then gestured toward her roommate (Resident #8). In an interview on 2/4/26 at 12:27pm, LPN OO reported Resident #13 had complained of nasal congestion for the past few days and the physician had ordered a nasal allergy spray for her approximately 2 days ago. LPN OO reported she did not know if the resident had been tested for covid since the onset of her symptoms. During an observation on 2/5/26 at 10:02am, no signage for transmission-based precautions was present outside Resident #13 and Resident #8's room. Review of an Interdisciplinary Progress Note for Resident #13 with a reference date of 2/5/26 revealed (Resident #13) is A&O (alert and oriented) .observed with cough/congestion.COVID test completed that was positive.Placed on isolation at this time. In an interview on 2/6/26 at 10:45am, Infection Prevention Manager (IPM) KK confirmed that any resident with symptoms of an acute respiratory illness should be placed in transmission-based precautions immediately and tested for covid. IPM KK confirmed there was a delay in implementing isolation precautions and testing of symptomatic residents. IPM KK reported Resident #76 tested positive for covid 19 on 1/31/26 and Resident #90 tested positive on 2/1/26. When further queried, IPM KK reported she had just returned from a medical leave and the facility had not immediately implemented all of its covid 19 protocols at the onset of having symptomatic residents/an outbreak. #2 During an observation on 2/5/26 at 10:04am, a mechanical lift device that sat outside room [ROOM NUMBER] was heavily soiled with dust and debris on the blue padding that residents place their hands on during transfers. The base of the device was soiled with large areas of dried white liquid. During an observation on 2/5/26 at 10:13am, a soiled mechanical lift device sat outside room [ROOM NUMBER]. Dried white liquid coated the right side of the base of the device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of her bed on the wall were splatters of dried tan/brown liquid fanning out across the wall, there was dried tan/brown liquid material dried on the tube feeding pole and base, there was dried tan/brown liquid material on the floor under the tube feeding pole, and on Resident #27's bed frame. The suction machine on her nightstand had thick particle dust covering the whole top of the machine, the nightstand was covered in various personal items as well which were cluttered on the nightstand. During an observation on 02/05/2026 at 12:28 PM, Resident #27 was in her bed. Behind the head of her bed on the wall were splatters of dried tan/brown liquid fanning out across the wall, there was dried tan/brown liquid material dried on the tube feeding pole and base, there was dried tan/brown liquid material on the floor under the tube feeding pole, and on Resident #27's bed frame. The suction machine on her nightstand had thick particle dust covering the whole top of the machine, the nightstand was covered in various personal items as well which were cluttered on the nightstand. o tube feeding observed to be running at this time, there was dried tube feeding on the pole and on the floor around the base of the pole. The suction machine did not have a date on it, and it was covered in dust and debris. The floor needed to be swept as there was dirt and debris on the floor. During an observation on 02/05/2026 2:02 PM, Resident #27 was in her bed. Behind the head of her bed on the wall were splatters of dried tan/brown liquid fanning out across the wall, there was dried tan/brown liquid material dried on the tube feeding pole and base, there was dried tan/brown liquid material on the floor under the tube feeding pole, and on Resident #27's bed frame. The suction machine on her nightstand had thick particle dust covering the whole top of the machine, the nightstand was covered in various personal items as well which were cluttered on the nightstand. o tube feeding observed to be running at this time, there was dried tube feeding on the pole and on the floor around the base of the pole. The suction machine did not have a date on it, and it was covered it dust and debris. Observed on the wall behind her bed, tube feeding pole and floor had dried tube feeding. and it was on the bed frame as well. During an observation and interview on 02/05/2026 at 1:47 PM, Licensed Practical Nurse (LPN) LL reported Resident #27 had a suction machine as a tube feeding resident all of them have one. LPN LL reported Resident #27 does become very congested with mucous during her menstrual cycle. LPN LL reported she does have a patch behind her ear for excess secretions. This writer pointed out the dried tan/brown tube feeding liquid along the wall behind her bed, the dried tube feeding liquid on the tube feeding pole and base, the floor and her bed frame. LPN LL reported housekeeping should have addressed this as they come in the room every day. LPN LL reported the nurse who had allowed the tube feeding to splatter across the wall, fall, bed, and tube feeding pole and base. Shared Equipment: During an observation on 02/04/2026 at 12:12 PM, observed a sit to stand machine between rooms , the base of the machine had dirt and debris on it, the footrests on the sides of the stem had dirt and debris on them. the knee pad area had dried whitish material on the top of it and on the right side back. During an observation on 02/04/2026 at 12:25 PM, observed a Hoyer outside room [ROOM NUMBER] which was observed to have dirt and debris on the footrest area, the blue pad which covered the fork for the hooks had dirt, debris, dried material staining the blue cover. During an observation on 02/05/2026 2:03 PM room [ROOM NUMBER] had a sit to stand outside along the wall, the footrest and the base were covered in dirt and debris, the knee pad had dried white (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	material on the top of it, and on the right side, facing it, there was streaked white dried material running down it. there was a container with micro kill bleach wipes on the machine.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a safe and sanitary environment, for 2 (Resident #4 and Resident #103) including a dusty and broken oscillating fan and an unkept resident room resulting in the potential for unsafe and uncomfortable resident environment.Findings include: Resident #4 Review of an admission Record revealed Resident #4 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: vascular dementia (cognitive impairments resulting from a decrease in blood flow), hemiplegia affecting the left non-dominate side (decrease use of the left side of the body) and cerebral infarct due to occlusion (stroke due to a blocked blood vessel). Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of 12/23/25 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #4 was moderately cognitively impaired. On 02/04/26 at 12:26 PM, 02/05/26 at 1:15 PM, and 02/06/26 at 9:15 AM, a small oscillating fan was observed on the bedside dresser in Resident #4's room. The fan was observed to be missing the cover, and the fan blades were exposed and covered in dust; the cover to the fan was observed under personal items on another bedside stand. A pedestal fan in Resident #4's room was observed to be covered in dust. On 02/06/26 at 9:15 Resident #4 was observed in bed, and a small oscillating fan was observed on the bedside dresser, on, with blades exposed and rotating and no cover in place. In an interview on 02/06/26 at 9:19 AM, Resident #4 reported the fan had been broken for a long time and she has asked for it to be fixed. Resident #4 reported she was concerned she would get her fingers in the fan when it was on. In an interview on 02/06/26 at 12:03 PM, Housekeeper (H) GG reported she was responsible for cleaning fans, and there was no set scheduled, they were cleaned as needed. In an interview on 02/06/26 at 12:31 PM, Maintenance Director (MD) EE reported fans were to be cleaned monthly and they were a part of the housekeepers' responsibilities. MD EE reported that he was usually the one that cleaned the fan covers. When MD EE was queried regarding the broken small oscillating fan on Resident #4's bedside dresser and the pedestal fan in Resident #4's room, MD EE reported the broken fan should have been replaced and the pedestal fan should be cleaned. On 02/06/26 at 12:37 PM, MD EE was observed replacing the small oscillating fan and returning the cleaned covers for the pedestal fan in Resident #4's room. Resident #103: Review of an admission Record revealed Resident #103 was a female with pertinent diagnoses which included heart failure, COPD, dementia, Alzheimer's disease (buildup of proteins as plaques and (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tangles in the brain, causing brain cells to die and the brain to shrink), anxiety and depression. During an observation on 02/04/26 at 11:40 AM, Observed a fall mat next to the side of the bed, which had crumbs, dirt and debris covering it. The floor around and under her bed had scattered dirt, debris, and crumbs on the floor. Resident #103's nightstand needed to be dusted as it and the items on top of it were covered in dust. During an observation on 02/05/2026 at 2:09 PM, Resident 103's room was still unkempt and needed to be dusted, swept and mopped. Using the reasonable person concept, though Resident #103 had decreased ability to verbally express her own thoughts due to her medical diagnoses, any reasonable person would likely feel a decreased sense of self-worth and frustration in the situations observed.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a Skilled Nursing Facility-Advanced Beneficiary Notice of Non-coverage (SNF-ABN) to 3 (Resident #123, Resident #124, and Resident #125) of 3 residents reviewed for proper notification related to Medicare A insurance coverage and facility care costs.Findings include:Resident #123Review of an admission Record revealed Resident #123 was a female who admitted to the facility on [DATE] and had pertinent diagnoses which included: chronic kidney disease stage 3 (mild to moderate damage to kidneys resulting in decreased ability to filter out water and fluid from the body).Review of SNF Beneficiary Protection Notification Review form for Resident #123, completed by Nursing Home Administrator (NHA) A on 02/05/26 revealed Medicare Part A Services Episode Start Date: 11/17/25 and Last covered day of Part A service: 12/19/25 and NHA A documented No, SNF ABN form was not provided to Resident #123 for Other- Resident (#123) started custodial care on 12/20/25 under Medicaid and Medicare Part B coverage.In an interview on 02/05/26 at 12:10 PM, Financial Services (FS) FF reported she was responsible for issuing SNF ABN forms to residents whose Medicare A benefits were ending. FS FF reported she did not issue the SNF ABN form to Resident #123 due to her transition to custodial care.The facility was unable to provide a documented Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage for Resident #123 prior to survey exit.Resident #124Review of an admission Record revealed Resident #124 was a female who admitted to the facility on [DATE] and had pertinent diagnoses which included: malignant neoplasm of overlapping sites of right female breast (a cancerous growth that has spread to multiple anatomical locations of the breast).Review of SNF Beneficiary Protection Notification Review form for Resident #124, completed by NHA A on 02/05/26 revealed Medicare Part A Services Episode Start Date: 10/23/25 and Last covered day of Part A service: 10/30/25 and NHA A documented No, SNF ABN form was not provided to Resident #124 for Other- Resident (#124) started hospice care on 10/31/25 under hospice - Medicaid coverage with (Name Omitted) Hospice provider.In an interview on 02/05/26 at 12:10 PM, FS FF reported she did not issue the SNF ABN form to Resident #124 due to her transition to Hospice care. The facility was unable to provide a documented Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage for Resident #124 prior to survey exit.Resident #125Review of an admission Record revealed Resident #125 was a female who admitted to the facility on [DATE] and had pertinent diagnoses which included: traumatic subdural hemorrhage without loss of consciousness (bleeding between the brain and its protective layers resulting from trauma).Review of SNF Beneficiary Protection Notification Review form for Resident #125, completed by NHA A on 02/05/26 revealed Medicare Part A Services Episode Start Date: 08/18/25 and Last covered day of Part A service: 09/09/25 and NHA A documented No, SNF ABN form was not provided to Resident #125 for The resident was discharged from the facility and did not receive non-covered services.In an interview on 02/05/26 at 12:10 PM, FS FF reported she did not issue the SNF ABN form to Resident #125 due to her choice to discharge from the facility. The facility was unable to provide a documented Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage for Resident #125 prior to survey exit.In an interview on 02/05/26 at 12:10 PM, FS FF reported she did not understand completely when SNF ABN form should be issued to residents where were transitioning from Medicare A insurance coverage.In an interview on 02/05/26 at 11:56 AM, NHA A reported she was not well versed on which forms should be issued when, but she was learning. NHA A reported she was not sure if SNF ABN forms should be issued for residents who were transitioning from Medicare A insurance services.In a telephone interview on 02/05/26 at 11:58 AM, Corporate Financial Service (CFS) JJJ reported Resident #123, Resident #124, and Resident #125 should have received a SNF ABN from when Medicare A services were being stopped and they were not issued the form. Review of facility policy Advanced Beneficiary Notice with a revision date of November 2022, revealed .to prepare and deliver to the resident or residents (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	authorized representative an Advanced Beneficiary Notice (ABN).when utilization review entity expects that Medicare probably will not pay for or will not continue to pay for extended care items.Purpose: to ensure that beneficiaries receive adequate notice of liability to pay for services denied.the facility will utilized the CMS approved From CMS-10055 for Medicare part A stay fee-for-service care Advanced Beneficiary Notice.

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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 #2735016. Based on interview and record review, the facility failed to protect the resident's right to be free from sexual abuse by a staff member. Findings include: Resident #114: Review of an admission Record revealed Resident #114 was a male with pertinent diagnoses which included multiple sclerosis (the body's immune system attacks the protective covering of the nerve cells in the brain and spinal cord, disrupting signal transmission), need for assistance with personal care, suprapubic catheter (thin, flexible tube inserted through a small incision in the lower abdomen directly into the bladder to drain urine), muscle wasting and atrophy multiple sites (loss of muscle tissue characterized by decreased size, strength, and function), depression, anxiety, and chronic pain. Review of current Care Plan for Resident #114, revised on 11/28/25, revealed the focus, .Altered functional mobility and ADL's (activities of daily living) related to: MS (muscle sclerosis), obstructive and reflux chronic pain syndrome, neurogenic bladder, debility and need for assistance with personal cares with the intervention .DRESSING: One assist with cueing and encourage to do as much for self as able.EATING: Provide physical assistance to accept nutrition by mouth.LOCOMOTION: Independent in wheelchair. Review of Interdisciplinary Documentation dated 01/26/2026 at 2:15 PM, revealed, .(Resident #114) reported an allegation of having an inappropriate non-work related relationship with a staff member. Notification made to NHA (Nursing Home Administrator), DON (Director of Nursing), NP (Nurse Practitioner) and Police. He is self-determined and doesn't wish to have family notified. Review of Facility Reported Incident dated 1/26/26, revealed, .Immediate Action: (Activities Director (AD) F) notified DON (Director of Nursing B) at 1530 (3:30 PM) 1/26/2026, NHA (Nursing Home Administrator A), at 1515 (3:15 PM) 1/26/2026 of the allegation that was made by (Resident #114). (Local County) Sherrif office was called at 1630 (4:30 PM) and (Deputy Sheriff PPP) responded to building in 1700 (5:00 PM) to interview resident, (Resident #114), and file a report. Complaint number 00063310. The alleged perpetrator was sent home immediately following the reported allegation and suspended pending investigation.Witness Interview: Alleged Victim Interview: (NHA A) and (Social Worker (SW) XX) Social Worker interviewed (Resident #114) on 1/26/2026 at 1730 (5:30 PM). (Resident #114) reports that on December 19, 2025, at 1300 (1:00 PM), he left facility on an LOA (leave of absence) per (accessible public transportation) bus to (Local Hotel) in [NAME], MI to stay overnight. He stated that he paid for the room. (Infection Preventionist QQQ) at facility met him there a few minutes after his arrival as they had planned. He brought with him a few vapes (a battery powered device that heats a liquid into an aerosol) and money. He alleges they spent the night together, having unprotected sex. The next morning, they left separately at approximately 10 AM. (Infection Preventionist QQQ) had asked him not to tell anyone about them staying together and he said he promised her he would keep it to himself. A couple days later he noticed $300 missing along with his vapes. He said he contacted her and asked about it, and she denied taking the money and said she was holding his vapes for him. While on video chat with her he said he could see his vapes on her chest as she was using it while talking to him. The relationship continued over (a social media platform) between them sharing videos, and she sent him a screenshot of a picture of her buttocks wearing only a thong.Staff Interview: (CNA P) CNA was asked to give written statement regarding what (Resident #114) had reported to her by (Director of Nursing (DON) B) Director of Healthcare Services on 1/27/2026. (Resident #114) reported to me that the prostitute is what he would call the manager. When he left the facility in December, he paid for that person. We asked who he was talking about and he would not tell us the name. He bought a Nike sweater, and it went missing. I usually help him. He said the Whore took it and got lost in her garage. There was no money on his side table. The next day there was $49.00 on the nightstand, which is how much the sweater cost. He said, the whore finally paid for the sweater. He says that it has been going on with (continued on next page)

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	235594	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Niles	1211 State Line Rd Niles, MI 49120

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Infection Preventionist QQQ's boyfriend), and her. I was feeding him and asked if he wanted to report it. I asked if he wanted to speak with (NHA A), NHA. He declined and wanted to speak with (Activities Director (AD) F), Life Enrichment, I reported it to (AD F), and she went to speak with him. Yesterday, he finally said he doesn't want her to take advantage of him and other people. I said, (Infection Preventionist QQQ), and he said yes. That is her. Then I left the room and he turned on the light. He pulled up the messages on the phone and showed pictures of her in her underwear. It was a phone-to-phone text message. I would see her go into his room for a while and come out with large clear trash bags. I couldn't tell what else was in the bag. I could see a sheet. I did not witness any inappropriate behavior, just what (Resident #114) reported. I have not witnessed anyone taking anything from him. Review of IDT Note dated 12/19/25 at 1:30 PM, revealed, .(Resident #114) left facility for overnight at 1300 (1:00 PM), sent with personal belongings of vape pens, knife, etc. Meds sent for the rest of today and 0800 (08:00 AM) tomorrow. Resident states he should return around 1200 tomorrow 12/20.Review of Interdisciplinary Documentation dated 12/19/2025 at 2:14 PM, .CENA (Certified Nursing Assistant) reported to this nurse that (Resident #114) stated he was taking 3,000 dollars cash with him and showed the CENA his money.Review of Interdisciplinary Documentation dated 12/20/2025 at 1:00 PM, .Resident returned from LOA (leave of absence), pleasant and denies c/o (complaints of) any discomfort and in good spirits.In an interview on 02/05/2026 12:44 PM Activities Director (AD) F reported CNA (Certified Nursing Assistant) P was one of the regular CNAs who took care of (Resident #114). AD F reported CNA P came to her to ask her to go and speak to (Resident #114) as he wanted to report someone from management. AD F reported she went to speak with Resident #114 (Resident #114). AD F reported (Resident #114) reported he had been used by (Infection Preventionist (IP) QQQ) and he proceeded to show her pictures of IP QQQ from his (a social media platform) messenger. AD F reported she was able to observe the photo and name attached to the profile and it was IP QQQs name and photo, and there were a ton of messages between them as he was scrolling his messages to show AD F the inappropriate picture IP QQQ had sent to Resident #114 of her backside wearing a thong as underwear. AD F reported Resident #114 reported when asked if it was IP QQQ, Resident #114 stated Who else it would be. AD F reported Resident #114 was scrolling fast in his phone and was unable to see any other pictures and reported he was looking for the specific photo. AD F reported Resident #114 reported the relationship started 12/4/26, as he had shown AD F several missed calls on (a social media platform)Time on that date. AD F reported Resident #114 reported it had started as IP QQQ was coming to his room and she was very friendly with him and IP QQQ started to contact him on (a social media platform) Messenger. AD F reported Resident #114 reported he rented a room, stayed with her there, and they had sexual relations. Resident #114 also reported IP QQQ had stolen his vapes, other stuff and probably took his money but he had no proof. AD F reported Resident #114 indicated to a nurse he might have a sexually transmitted disease (STD) after their sexual encounter, thought IP QQQ had given him an STD and IP QQQ had come to his room and asked him why he was asking for an STD test. AD F reported Resident #114 reported IP QQQ had come to his room another time and asked if he was going to tell anyone about their relationship. AD F reported after Resident #114 had reported to her, she asked Social Worker (SW) XX to go with her to check on Resident #114, but he was getting ready to leave the facility but Resident #114 did confirm he felt IP QQQ had used him and he asked if he was going to get in trouble for reporting her. AD F reported Resident #114 reported IP QQQ had contacted him at approximately 2:00 AM the night before she and SW XX went to speak to him and IP QQQ was crying and asked why he had reported their relationship, and she had been suspended because of it. In an interview on 02/05/2026 2:22 PM Certified Nursing Assistant (CNA) P reported she had been providing feeding assistance to Resident #114, and he reported when he went out in December, he was with a whore that worked here. CNA P reported that morning he reported he was tired of her (IP QQQ) stealing from him and he didn't want her to continue to take advantage and hurt anyone else at other facilities, so he told me her name, it was IPQQQ, who worked as the infection preventionist, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when he went out in December to a hotel and it was also her who had been in and out of his room and Resident #114 reported he thought he had gotten syphilis from her that was why he wanted to get tested but then declined. CNA P reported Resident #114 had bought a Nike hoodie which ended up being too small for him and she was going to help him return it, when she asked Resident #114 where the hoodie was at, he reported the whore took it and got lost in her garage. CNA P asked Resident #114 who the person was he would not tell her but after that Resident #114 had found money on his nightstand and it had dawned on him the money had come from IP QQQ to replace the lost hoodie. CNA P reported she noticed IP QQQ had been going in and out of Resident #114's room more frequently, leaving with bags of linen and CNA P reported she was unsure why she was going to his room more frequently but thought it might be infection control related. CNA P asked Resident #114 who he would like to report his concern to and he indicated he would like to talk with AD K. CNA P reported she had left Resident #114's room and the call light turned back on, and Resident #114 needed his phone, and he needed her help with his phone, helped scroll to where he wanted her to stop and at the top of the screen was IP QQQ's name and picture and a picture of her butt in thong underwear. CNA P reported there were several other text messages between them. CNA P reported Resident #114 reported IP QQQ was still trying to contact him. CNA P reported Resident #114 reported the relationship between them started not long after she started at the facility. CNA P reported Resident #114 reported IP QQQ had reached out to him on (a social media platform) initially. CNA P reported Resident #114's (a social media platform) profile was not his first name it was his middle name, and she would have to know his middle name to find him. CNA P reported Resident #114 hid his (a social media platform) profile because of his child. Resident #114 reported IP QQQ had mentioned when he had spilled his Gatorade in his room, she had come to his room, he was always naked in his room, and she was pursuing him after that. In an interview on 02/05/2026 1:20 PM Social Worker (SW) XX reported she went with the NHA A when she interviewed Resident #114 and she wanted to make sure he felt safe and supported, asked if he needed anything. When the police arrived to take his statement, she reported she left the room so they could conduct their interview. In an interview on 02/05/26 at 5:51 PM, Deputy Sheriff (DS) PPP reported during her investigation it was determined IP QQQ had sought out Resident #114 for a relationship. DS PPP reported she was informed no sexual intercourse happened at the facility possibly some kissing only per Resident #114. DS PPP reported Resident #114 reported he had gone out on leave on December 19, 2025, and they had met at the hotel. Resident #114 had taken a ride service and IP QQQ had arrived at the hotel in her motor vehicle. Resident #114 reported they had sex, she stayed the night with him at the hotel. Resident #114 alleged he had $300.00 missing as well as some vapes which Resident #114 had observed in her possession. DS PPP reported she had interviewed IP QQQ who reported she had fallen in love with him and agreed to meet Resident #114 at the hotel. DS PPP reported IP QQQ reported there was no sexual penetration but there was sexual activity. DS PPP reported IP QQQ reported she had no financial motive to take Resident #114's money and indicated she had broken up with Resident #114. DS PPP reported she had reviewed the surveillance footage at the hotel, and both were observed in the lobby of the hotel together and it appeared to be beyond a nurse resident relationship. DS PPP indicated the report was with the prosecutor for review. This writer attempted to contact IP QQQ prior to exit. No return call was received. This writer attempted multiple times during the survey 2/4/26 - 2/10/26 to speak with Resident #114 but did not want to be interviewed. In an interview on 02/10/2026 10:49 AM NHA A reported Resident #114 reported to CNA P he was taken advantage of by a nurse, AD F went to interview him and Resident #114 reported to her, he had a relationship with IP QQQ which began on (a social media platform) Messenger with texting, sending photos and videos back of her butt and her breasts. AD F came and reported the incident to me and SW XX came with me when she went to interview Resident #114. NHA A reported Resident #114 had told her the same recount of the relationship and observed there were photos and messages. NHA A reported IP QQQ was suspended pending investigation. NHA A reported IP QQQ indicated she had been hacked, had not reported her (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accounts being hacked and just had deleted her accounts, and was unable to provide any documentation of reporting being hacked. NHA A reported IP QQQ reported all the messages and photos were sent by the person who hacked her accounts. NHA A reported Resident #114 reported they had stayed together at the (Local Hotel), he took $3000 with him, and she took $300 from him as well as his vapes, reported after the relationship ended Resident #114 asked for his items back and IP QQQ would not return his items. NHA A reported IP QQQ denied everything, there was no calls, texts, spending the night. NHA A reported she had attempted to contact the sheriff to obtain a copy of the final report but had not received one yet. NHA A reported she was waiting to hear from the sheriff to see if they were able to review the footage at the hotel. NHA A reported IP QQQ was terminated due to the policy of not informing the NHA of having a relationship outside of the facility.

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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** Based on interview and record review, the facility failed to report an incident of potential neglect (elopement) to the State Agency for 1 resident (Resident #109) of 1 resident reviewed for reportable incidents resulting in the potential for additional reportable incidents to not be reported and cause a delay in the investigative process.Findings include: Resident #109 (R109)During an interview on 2/5/2026 at 3:04 PM, R109 Guardian (G) BBB stated that R109 can smoke outside with R47's daughter or a staff member but not by herself. G BBB stated R109's face sheet should show who she was able to go out with. Review of R109's face sheet revealed Special Instructions.(R109) is allowed to go outside and leave facility with (R47's daughter) or (Senior Services staff name omitted) only per her guardian. Review of the Wandering Risk assessment dated [DATE] revealed .Assessment Summary: (R109) is not a wandering risk, she does wear a wander guard (wearable electronic tag to monitor movement and can trigger alarms when a resident enters a restricted area) to alert staff if she is attempting to exit the building. She is a smoker and wants to go outdoors and smoke in unsafe undesignated areas. (R109) moves about with purpose and a destination.Review of R109's incident report dated 1/1/2026 revealed Nursing Description: (R109) exited the building at 1855 (6:55 PM). The main entrance door alarm was sounding and (R109) was outside sitting on the sidewalk between the main entrance and the office entrance. (R109) was wearing a brown winter coat backwards covering the front of her body with her arms in the sleeves, winter boots, and pajama pants. Resident Description: they let me outside when asked who let you outside, she stated I don't know I went outside and sat on the sidewalk to the right of the door, smoked my cigarette and came back in. Was this incident witnessed: N (No). Immediate Action Taken: Description: . (R109) educated. Staff educated on the door alarm procedure. Skin Assessment performed. No s/sx (signs/symptoms) of injury, bruising, redness, or skin impairments noted. (R109) exhibited no s/sx of psychosocial distress. Psychosocial needs remain at baseline. Activity Aide (AA) KKK's statement communicated to previous Director of Nursing (DON) revealed that AA KKK turned off the alarm and a resident (Resident #120) told her that R109 set off the alarm then she notified Licensed Practical Nurse (LPN) PP. LPN PP's statement communicated to previous DON revealed that he told AA KKK he would keep an eye on R109 when she was outside smoking her cigarette and then she came inside soon afterwards. LPN PP also stated to the previous DON that he was aware of (R109) going outside on previous occasions. During an interview on 2/5/2026 at 4:16 PM, R109 stated that she goes out of the building to smoke with Resident #47's (R47's) daughter when she visits. R109 said she didn't leave the building on 1/1/2026 to smoke by herself. Review of the interdisciplinary documentation progress note dated 1/2/2026 completed by Social Worker (SW) XX revealed SS (Social Services) met with resident several times this morning in regard to behaviors. SS attempted to discuss resident's continuation of exit seeking and going outside to smoke. Resident denied smoking in over a month. SS told by staff that resident was outside smoking last night. During an interview on 2/5/2026 at 12:58 PM, NHA A' stated that R109 wants to go outside unsupervised for smoking and she wasn't safe to do that. NHA A said that R109 snuck out with another resident on 1/1/2026 and was by the activity window and AA KKK saw her the whole time. During an interview on 2/5/2026 at 4:01 PM, AA KKK stated that she didn't know R109 left the building and went outside to smoke until Resident #120 told her when he came back inside from smoking. AA KKK said that when she found out that R109 was outside by herself, she yelled for LPN PP to get R109 from outside because she was doing an activity with residents. Then, AA KKK said she saw R109 coming back inside and wasn't sure how she came back in the building. AA KKK reported that she told Activity Director (AD) F about R109 leaving the building the next day on 1/2/2026. AA KKK stated that she was written up by the previous Director of Nursing (DON) for not following the policy and responding to the alarm when R109 went outside. During an interview on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/6/2026 at 8:39 AM, LPN PP stated he was down the hall passing medications when AA KKK told him that R109 was outside smoking by herself. AA KKK told him that she couldn't leave the residents in the activity, so LPN PP said he kept an eye on her from inside. LPN ?PP reported that he continued to pass medications and could see R109 through the window smoking outside. LPN PP stated that he did not see R109 leave the building but saw her come back in. LPN PP also said that he did not report the incident to NHA A or the DON at the time because he didn't think it was a concern since she had gone out to smoke before. LPN PP reported that he wasn't written up by the previous DON, she just spoke to him about responding to alarms and following the policy. During an interview on 2/6/2026 at 12:46 PM, Housekeeper (H) HH stated on 1/1/2026 she turned off the alarm to let R109 back into the facility when R109 was done smoking. H HH said she did not see R109 leave the building. During an interview on 2/6/2026 at 8:24 AM, AD F stated that AA KKK was written up for not following the elopement policy and responding to the alarm by the previous DON. AD F said AA KKK notified her the next day on 1/2/2026 about the incident and then she (AD F) reported it to NHA A. During an interview on 2/6/2026 at 8:54 AM, Clinical Care Coordinator (CCC) CC stated that R109 had a wander guard since 7/10/2025 due to exit seeking behavior and wanting to leave the facility to smoke. CCC CC stated that R109 cannot go outside by herself. During an interview on 2/6/2026 at 9:13 AM, Social Worker (SW) XX stated that R109 can't go outside by herself to smoke and her face sheet had instructions on who can take her out to smoke. SW XX reported that staff knew she was an elopement risk since her picture was in the staff break room and in the elopement books at all the nurses' stations. Also, SW XX stated that she had a wander guard to alert staff when she tried to leave the facility. During an interview on 2/6/2026 at 12:51 PM, DON B stated she wasn't the DON when the incident occurred on 1/1/2026. DON B said that she couldn't speak to why the elopement wasn't reported on 1/1/2026 but if staff didn't see R109 leave the building it should have been considered an elopement and should have been reported. During another interview on 2/06/2026 at 12:56 PM, NHA A stated that she didn't think the elopement on 1/1/2026 needed to be reported since the corporate office was involved and said it didn't meet the criteria to be reported. NHA A said that AA KKK had eyes on R109 when she left the building and when she was outside and AA KKK saw R109 the whole time until she brought her back in from outside. NHA A stated that an elopement should be reported when staff didn't see the resident leave the building and when they didn't have eyes on them the whole time they were outside. It was discussed that staff did not see R109 leave the building and left her outside to continue smoking and NHA A said she was not aware of that. NHA A reported that that the previous DON notified her about the elopement the next day on 1/2/2026 at 12:38 PM but she did not report the incident to the State Agency.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure proper procedure for a facility-initiated discharge for 1 (Resident #120) of 1 resident reviewed for facility-initiated discharge resulting in the unapproved discharge of the resident from the facility.Findings include: Resident #120Review of an admission Record revealed Resident #120 was a male who admitted to the facility on [DATE] and had pertinent diagnoses which included: acute osteomyelitis left ankle and foot (sudden and severe bone infection, often caused by bacteria).Review of a Minimum Data Set (MDS) assessment for Resident #120, with a reference date of 10/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #120 was moderately cognitively impaired.Review of Interdisciplinary Documentation for Resident #120 on 01/05/26 at 14:52 (2:52 PM) revealed .attempted to speak to Resident #120 this day in order to plan a safe D/C (discharge).This resident normally responds to discussions for D/C that he plans to leave in his van.Review of Interdisciplinary Documentation for Resident #120 on 01/06/26 at 12:29 PM, revealed .attempted to offer boxes for Resident #120 to pack up belongings and assist with D/C scheduled for today.Resident #120 became very aggressive stating that nobody is going to send him and he will just get in his van and leave.Review of Interdisciplinary Documentation for Resident #120 on 01/06/26 at 17:08 (5:08 PM) revealed .Resident #120 responded negatively to D/C scheduled for today. Resident #120 was issued a 30-day D/C on 12/04/25.Review of Notice of involuntary transfer or discharge and facility-initiated discharge for nursing homes for Resident #120 dated 12/04/25 revealed Resident (#120) did not have a guardian or resident representative.Reasons for transfer or discharge (a state and federal must be selected): state requirements- none were selected; CMS (Centers for Medicaid and Medicare Services) requirements- Resident no longer needs services provided by the facility.Has the resident had a recent level of care determination that negatively affects his or her ability to receive Medicaid covered services within the facility- answer yes; If yes, has a final determination been issued by the Michigan Department of Health and Humans Services (MDHHS), Answer- No; If no, an involuntary transfer or discharge cannot be issued to a resident until the final determination has been issued by MDHHS.Transfer or Discharge Destination- private residence- no address was provided for location of discharge, proposed date was 1/12/2026.Transfer or Discharge Timeline, Discharge Plan.If Michigan Department of Licensing and Regulatory Affairs ([NAME]) determines that a transfer or discharge is authorized, the resident shall not be required to transfer or discharge from the facility before the 34th day following receipt of the notice. prior to any involuntary transfer or discharge, a transfer or discharge plan must be prepared by the nursing home and approved by [NAME].The notice was signed by Nursing Home Administrator (NHA) A and dated 12/04/25.In an interview on 02/10/26 at 10:11 AM, NHA A reported she provided Resident #120 a 30-day notice on 12/04/25, because he no longer qualified for services. NHA A reported she filed the notice of involuntary transfer or discharge and facility-initiated discharge for nursing homes for Resident #120 on 12/04/25 with [NAME] and received confirmation of receipt. NHA A reported when she served Resident #120 with the 30-day notice he agreed to leave the facility in 30 days. NHA A stated he (Resident #120) drove his van here, had it in the parking lot, and that was his discharge plan, to live in his van.Review of electronic communication (E-mail) with [NAME]-BCHS-Involuntary Transfer on 02/10/26 at 11:11 AM, revealed Queried- regarding an approved involuntary discharge for (Name Omitted) Resident #120 submitted by the facility on 12/04/25?Review of reply E-mail communication with [NAME]-BCHS-Involuntary Transfer on 02/10/26 at 11:25 AM revealed .The involuntary discharge was never approved as the facility never submitted a discharge plan for the resident (Resident #120). The process was initiated on 12/16/25 by the facility where they stated the resident agreed to discharge to an AFC (adult foster care), was independent and owned a van that he used to come and go from the facility.In an interview on (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/10/26 at 12:15 PM, NHA A reported she did not complete the Facility involuntary transfer/discharge plan (Form IDT 101) for Resident #120 because he did not have an actual location he was to discharge to. NHA A reported she did not receive approval for Resident #120 to be discharged from the facility from [NAME]-BCHS-Involuntary Transfer.The facility was unable to provide a facility involuntary transfer/discharge plan (Form IDT 101) for Resident #120 prior to survey exit. Review of admission Record for Resident #120 revealed Date of Discharge 01/06/26 at 15:46 (3:46 PM) discharged to private home/apt. with no home health services.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Niles	1211 State Line Rd Niles, MI 49120

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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. Based on observation, interview, and record review, the facility failed to implement resident comprehensive care plans for 1 resident of 22 (Resident #27) reviewed for care planning resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being.Findings include: Resident #27: Review of an admission Record revealed Resident #27 was a female with pertinent diagnoses which included stroke, contractures (a permanent tightening of muscles, tendons, skin caused the joint to shorten and become very stiff) right elbow, right hand, and right ankle; contractures left elbow, hand, and ankle; abnormalities of breathing, epilepsy, and tube feeding due to a persistent vegetative state. Review of Care Plan for Resident #27 revised on 11/12/24 revealed the focus, . (Resident #27 is dependent on the staff for all ADL cares related to her persistent vegetative state. She has contractures to bilateral upper extremity joints and bilateral ankles. with the intervention .FALL - RISK MANAGEMENT: * Low bed in lowest position except with direct care .Comfort rounds to assess positioning and assistance to reposition. During an observation on 02/04/2026 at 12:08 PM, Resident #27 was observed lying in her bed. Her bed was not in the lowest position. Resident #27 was a taller person and took up most of the space of the length of the bed as well as the width of the bed. During an observation on 02/05/2026 at 12:28 PM, Resident #27 was in her bed, and her bed was not in the lowest position. During an observation on 02/05/2026 at 2:02 PM, Resident #27 was lying in her bed, and her bed was at transfer height, not in the lowest position. During an observation on 02/06/2026 at 12:15 PM, Resident #27 was observed in bed, supine position, arm contracted upward, bed was at transfer height, not at the lowest position. During an observation and interview on 02/05/2026 at 1:47 PM, Licensed Practical Nurse (LPN) LL reported Resident #27 had a suction machine as a tube feeding resident all of them have one as well as she does become very congested with mucous during her menstrual cycle. LPN LL reported when she does cough, she was a very active cougher as well as she had seizures, so staff checks her positioning, so she was not close to the side of the bed. In an interview on 02/10/2026 at 10:03 AM, Certified Nursing Assistant (CNA) SSS reported the CNAs can review the interventions for each resident on how to care for the residents. CNA SSS reported most of the time the CNAs care for the same residents for continuity of care and changes do get communicated to us by the nurses as well. In an interview on 02/06/2026 at 11:45 AM Clinical Care Coordinator (CCC) AA reported the CCCs were the staff responsible for maintaining the care plans for the residents. CCC AA reported the team discussed the residents and any changes. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident 's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident 's written plan of care .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2715364. Based on interviews and record review, the facility failed to identify an acute change in condition for 1 (Resident #121) of a total sample of 22 residents reviewed for quality of care resulting in a delay in treatment for Resident #121 who was sent to the hospital on 1/8/26 and diagnosed with altered mental status and septic shock (life-threatening condition caused by a severe infection) from necrotic (death of cells in tissue) sacral ulcer with osteomyelitis (infection in a bone). Findings include: Resident #121Review of an admission Record revealed Resident #121 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcer of sacral region stage 4, and need for assistance with personal care. Review of Resident #121's Care Plan revealed, (Resident #121) has the potential for an acute condition change with cardiopulmonary, metabolic or infectious complicationsrelated to atrial fibrillation (irregular heart rhythm) and orthostatic hypotension (sudden drop in blood pressure when standing up, causing dizziness, lightheadedness, or fainting)Date Initiated: 12/19/2025. Goals: (Resident #121) will have early identification, management, treatment and resolution of an acute condition change. Interventions: Assess and document edema, breath sounds, circumoral (around the mouth) or nail bed cyanosis (bluish skin discoloration), Assess and intervene as indicated for chest pain, Assess heart rate and rhythm prn (as needed), Blood Sugars as Ordered, Check oxygen saturation levels SA02% (sic) ad capillary refill prn (as needed), initiate 02 (oxygen) as ordered, Conduct an assessment of the resident prior to initiating health care practitioner contact, Ensure effective communication of resident condition to members of the interdisciplinary staff, Evaluate pain with the pain assessment monitor on the MAR (Medication Administration Record, Obtain baseline labs as ordered by the physician review and compare lab value results prn; assess abnormal values as indicated, Report any significant change to the physician and appropriate responsible party as indicated prn, Review advanced directives and know residents wishes for treatment, Vital signs prn. Date Initiated: 12/19/2025 .Review of Resident #121's Documentation of Symptoms for Sacral wound indicated findings of increased drainage on the following dates: 12/29/25,12/30/25,12/31/25, 1/3/26,1/4/26, and 1/8/26, findings for foul order on the following dates: 12/29/25, 12/30/25, 12/31/25, 1/3/26, 1/4/26, and 1/8/26, findings for Surrounding warmth on the following dates: 12/31/25, 1/3/26, 1/4/26,1/8/26 and 1/8/26, and findings for Surrounding edema (swelling) on 12/31/25, 1/3/26, 1/4/26, and 1/8/26 . Noted that all findings were the indication of the wound infection. Review of Resident #121's Hospital Records dated 1/8/26 revealed, . ED Course: . presents by EMS (Emergency Medical Services) for altered mental status and concern of worsening sacral wound. Per EMS, the patient is typically A&O (alert and oriented) x4 and is able to ambulate. Over the last few days patient has had worsening mental status and is not ambulating. Reportedly SNF nurses were concerned that sacral wound was worsening. Reportedly SNF (Skilled Nursing Facility) nurses were concerned that sacral wound was worsening .Examination of sacral wound shows wound with VAC in place. There appears to be erythema surrounding wound with fluctuance (boggy sensation felt on palpitation, indicating a fluid filled area) present . Purulence (pus that is produced in infected tissue) noted near the tailbone . Hospital Course: . Septic shock from necrotic sacral ulcer with osteomyelitis, Bacteroides and gram positive bacilli bacteremia (presence of bacteria in the bloodstream), Pseudomonal UTI (urinary tract infection). s/p (status post) incision and drainage of sacral wound 01/09, bone biopsy shows osteomyelitis. ID (Infectious Disease) consulted . Wound Care Consult Note 1/9/26: 2. Coccyx/sacral wound 10.5 x 11 x unable to assess due to necrotic tissue with bone exposed and palpable wound connect under necrotic tissue. Undermining circumferential in varies depth to uncomfortable for patient to obtain measurement. Peri wound skin erythema/nonblanchable /odor noted. Right lower leg lateral 7.6 x 3.9 x tissue purplish/black. Right anterior lower leg 3.5 x 1.1 x necrotic. Left lateral ankle 8 x 4 x Deep tissue injury Assessment: . 2. Unstageable pressure ulcer (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coccyx/sacral. 3. Right lower leg lateral unstageable pressure injury versus Deep tissue injury 4. Right anterior lower leg unstageable pressure injury 5. Left lateral ankle appears to be deep tissue injury evolving 6. Skin tear left arm . Infectious Disease Consultation 1/14/26: . On 01/09/2026 patient had incision and drainage and debridement of the sacral wound with bone biopsy taken that is showing acute osteomyelitis . In an interview on 2/04/2026 at 1:23 PM, Family Member (FM) FFF reported Resident #121 had been admitted to the facility on [DATE] after being hospitalized due to his coccyx wound. FM FFF reported that Resident #121 had admitted to the facility to continue receiving wound care treatments. FM FFF reported Resident #121 was typically alert and oriented, and able to ambulate in his wheelchair. FM FFF reported she first noticed that something seemed to be wrong with Resident #121 during a care conference at the facility on 12/24/25 when she noted that Resident #121 seemed to be noticeably more confused. FM FFF reported she had voiced her concern that Resident #121 seemed more confused than usual and was told that staff would get back with her regarding this. FM FFF reported on 12/26/25 she found Resident #121 lying in his room and that he appeared very pale and ill. FM FFF reported the nurse caring for Resident #121 had informed her that Resident #121 had not had his sacrum dressing changed because the facility was waiting on supplies to come in. FM FFF reported she continued to voice her concerns about Resident #121 condition, but she felt that staff were not taking her concerns seriously. FM FFF reported she was called by LPN TT on 12/29/25 and told that Resident #121's wound looked worse, and that she was waiting for the wound doctor to look at it before putting the wound vac back on. FM FFF reported that she did not hear back from the facility about Resident #121's condition after she had talked with LPN TT on 12/29/25. FM FFF reported she went to visit Resident on 1/5/26 and noted that Resident #121 could hardly talk and seemed confused or sedated. FM FFF reported that she spoke with the nurse caring for Resident #121 and expressed her concerns that Resident #121 was declining, FM FFF reported that staff reported that they would look into it again. FM FFF reported that she called the facility's Social Worker (SW) on 1/6/26 to discuss her concerns that Resident #121 was declining, and that she received a call back from on 1/7/26 from SW XX that the facility had a call into the doctor at the facility to see Resident #121. FM FFF reported that the next day, 1/8/26, Resident #121 was transported to the emergency room where he was admitted to the hospital. FM FFF reported that Resident #121 was transferred to the Intensive Care Unit (ICU) and had to have surgery the following day on his sacrum wound. FM FFF reported that she had spoken with the facility's Nursing Home Administrator (NHA) A on 1/9/26 and expressed her concerns about Resident #121's health decline and the facility response. FM FFF' reported that she was told the facility was investigating her concerns. FM FFF reported that she received a follow up call from Clinical Support Nurse (CSN) AAA where she was informed that the facility had not provided care for Resident #121's up to the facility standards, and that the facility was investigating her concerns. FM FFF reported that she never heard back from the facility staff after her call with CSN AAA. During an interview on 2/05/2026 at 11:34 AM, Certified Nursing Assistant (CNA) P reported she cared for Resident #121 often. CNA P reported that when Resident #121 first came to the facility he was alert, very kind, and required assistance of 1 staff member for ADL (Activities of daily living care) and then he seemed to go downhill all of a sudden. CNA P reported that Resident #121 became combative and he became unable to feed himself. CNA P reported that it seemed like she noticed the change in Resident #121 began when the facility took his wound vac off. CNA P was not aware of the date that the facility had removed Resident #121's wound vac. During an interview on 2/05/2026 12:41 PM, CNA S reported she had cared for Resident #121 and was familiar with him. CNA S reported Resident #121 did seem to quickly decline after he was admitted to the facility. CNA S reported Resident #121 began to require more assistance, seemed more confused and was getting more combative. During an interview on 2/05/2026 at 11:40 AM, LPN TT reported that she had cared for Resident #121 multiple times since he had been admitted to the facility. LPN TT' reported Resident #121 had declined after he was admitted to the facility, and Resident #121's family member had expressed concerns related to his decline. LPN TT reported she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had thought that nurses had told NP MMM about Resident #121's decline, but she was not sure what NP MMM had done for Resident #121. LPN TT reported that on 12/29/25, as she changed Resident #121's wound vac, she observed bone in Resident #121's sacral wound, and that the wound was black and the tissue was necrotizing. LPN TT reported that the wound appeared to be worsening. LPN TT reported that she was instructed by Former Director of Nursing (F-DON) UU to remove Resident #121's wound vac, apply a wet to dry dressing, and contact Resident #121's wound clinic. LPN TT reported that she had tried to find what wound clinic Resident #121 had gone to, but she was unsuccessful, and she did not know if the facility was ever able to arrange a wound clinic appointment for Resident #121. LPN TT reported that when Resident #121 was sent to the hospital on 1/8/26 she had found a wound on his right leg that she did not know was even there, and she did not think that facility had treatment orders in place for Resident #121's leg wound. During an interview on 2/05/2026 at 11:57 AM, LPN PP reported that he had cared for Resident #121, and that he recalled that Resident #121 seemed to need more assistance with care after he was admitted to the facility. LPN PP reported that he had completed wound care on 1/7/26, he had noticed that Resident #121's wound did not seem to be improving, and that there were brownish slough (dead tissue) spots across the wound. LPN PP did not recall if he had notified the facility's provider that Resident #121's wound was worsening. During an interview on 2/05/2026 at 4:27 PM, LPN SS reported on 12/26/25 during Resident #121's wound care treatment she noted that the wound looked much worse than when Resident #121 was first admitted , and it was bigger in size. LPN SS reported that there were several areas where the tissue on the wound was black. LPN SS reported she had noticed that Resident #121 had seemed to have declined, and that Resident #121's family member had also voiced concerns about his decline. LPN SS reported that Resident #121 was more confused and needed more assistance than when he was first admitted . LPN SS reported that she thought she had a left a note in the provider book for NP MMM, but she could not recall when. During an interview on 2/05/2026 at 1:06 PM, Clinical Care Coordinator (CCC) CC reported Resident #121 was admitted with a wound vac on his sacral wound, and that the dressing was supposed to be changed three times a week. CCC CC reported that she did not think that the facility was aware that Resident #121 was supposed to follow up with a wound clinic on 1/1/26. CCC CC reported that the facility submitted a referral to a wound clinic for Resident #121 on 12/31/25, and that he was scheduled for 1/14/26. CCC CC confirmed that she was aware that staff and Resident #121's family had expressed concerns that he was declining, and that she thought that NP MM was aware. During an interview on 2/5/26 at 2:13 PM, NP MMM reported that she was aware of staff and family concerns that Resident #121 was declining. NP MMM reported that she had saw Resident #121 around New Years and ordered lab work which looked good with the exception of an abnormal CRP (lab test used for assessing inflammation in the body and can aid in diagnosing and monitoring various health conditions) but since Resident #121 had a wound, she was not concerned. NP MMM reported when she saw Resident #121 on 1/8/26, he did not look good and he was not eating, so she ordered that Resident #121 be sent to the hospital. NP MMM reported that she had never been made aware that Resident #121's wound was hot to touch. During an interview on 2/05/2026 at 1:54 PM, F-DON UU reported Resident #121 was admitted to the facility with a wound vac on his sacral wound. F-DON UU reported at one point the facility was questioning the wound care order and trying to figure out if Resident #121 was supposed to go to a wound clinic, but she was not aware of what the facility determined for Resident #121's wound clinic referral. F-DON UU reported that she did not notify NP MMM about the change in Resident #121's wound condition on 12/29/25, but she thought that LPN TT had. During an interview on 2/05/2026 at 2:19 PM, CSN AAA reported that she had been made aware on 1/9/26 that Resident #121's family had concerns with his care at the facility from NHA A. CSN AAA reported that she had conducted an investigation with NHA A into Resident #121's family concerns. CSN AAA confirmed that the facility had been made aware of Resident #121's family concerns about Resident #121's potential decline on 12/24/25, and that the facility had planned to follow up with Resident #121's family with an update (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	once they had reviewed his lab work. CSN AAA confirmed that NP MMM did not see Resident #121 until 12/31/25 and labs were not ordered for Resident #121 until 12/30/26. CSN AAA was unable to report when or if nursing staff had notified NP MMM of Resident #121's decline in function, or if NP MMM had been notified about the change in Resident #121's wound condition. CSN AAA confirmed that she had found several missing treatments and documentation of Resident #121's change in condition, and that the facility had been re-educating nursing staff on this. In a follow up interview on 2/06/2026 at 8:54 AM, LPN TT confirmed that she did notify NP MMM on 12/29/25 about Resident #121's wound via text. LPN TT reviewed the text that she sent to NP MMM which indicated that she had concerns with Resident #121's wound, and that she changed his dressing to a wet to dry. NP MMM replied that she had received the text and would be in to look at Resident #121. LPN TT reported that she did not receive any follow up orders from NP MMM and she did not know when or if Resident #121 was seen by NP MMM or if his wound care orders were changed. Review of Resident #121's Progress Note dated 12/29/25 and documented by Licensed Practical Nurse (LPN) TT revealed, LPN attempted to change wound vac (negative pressure wound therapy device that uses gentle suction to promote faster and more effective wound healing) dressing. Dressing removed. LPN observed wound down to bone in right buttock wound. Left buttock wound does have some tissue left. Tissue between both wounds is necrotizing. Peri wound is red, hot to touch. (Former Director of Nursing (F-DON) UU) aware. Instructed to wet to dry (applying moist gauze to a wound, followed by dry gauze, then allowing it to dry completely and stick to dead tissue so that when it is removed the dead tissue comes with it) and call wound clinic. Wound clinic called, LPN left message on nurse line at (number redacted) for further instruction. Awaiting call back. Family aware . Review of Resident #121's Progress Note dated 12/29/25 and documented by LPN TT revealed, (wound care provider) does not see (Resident #121) for wound vac. LPN left message with (Nurse Practitioner (NP) MMM) for further instructions. Review of Resident #121's Progress Note dated 12/30/25 revealed, Resident recently declined, (NP MMM) consulted. labs to be obtained STAT .Review of Resident #121's Progress Note dated 12/31/25 revealed, .Wound vac remains on hold until further wound care evaluation completed. Wound is larger, with necrotizing tissue in the middle and bone exposure observed. Wet to dry dressing maintained at this time.Review of Resident #121's Progress Note dated 12/31/25 and documented by NP MMM revealed, Infected decubitus ulcer-Completed Augmentin and Bactrim (antibiotics) for total of 7 days. Continue wound vac, follow up with wound clinic on 1/14 .Review of Resident #121's Progress Note dated 1/6/26 revealed, . Wound care completed to buttocks, wet to dry. Wound drainage green/yellow, odor increased. Tenderness increased. Not able to participate in therapies at this time .Review of Resident #121's Progress Note dated 1/7/26 revealed, wound vac placed without much difficulties. resident tolerated procedure well. Review of Resident #121's Progress Note dated 1/8/26 revealed, (Resident #121) is being sent to the ER for further evaluation of altered mental status and ? infection (sic). Order received from (NP MMM) to send patient to the ER . Review of the facility's Change in Resident Condition policy last reviewed January 2026 revealed, Policy: It is the policy of this facility to inform the resident; consult with the residents health care practitioner, and notify the residents authorized representative according to the minimum guidelines established in this procedure and more frequently at the discretion of the licensed nurse or member of the interdisciplinary team. Purpose: To ensure provision of the necessary care and services to meet the highest practicable physical, mental and psychosocial well-being of each resident in accordance with measurable objective assessment data. Procedure: 1. The health care practitioner will be promptly notified when . b. The resident has a significant change in physical, mental, or psychosocial status i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. c. A resident assessment indicated the need to alter the treatment significantly i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new treatment . 6. Objective observations of changes in a resident's condition, including emotional changes as a means for analyzing and determining care (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required and the need for further medical evaluation and treatment shall be recorded in the resident's record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to adequately supervise, reduce hazards, and ensure the safety of 2 (Resident #109 and Resident #32) of 7 residents reviewed for accidents/hazards resulting in an elopement and a fall. Findings include: Resident #109 (R109) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R109's initial admission date was 5/2/2025 with pertinent diagnoses including anxiety, post-traumatic stress disorder, bipolar disorder (intense mood swings ranging from extreme highs and lows), mild cognitive impairment and depression. Brief Interview for Mental Status (BIMS) reflected a score of 10 out of 15 which indicated R109 cognition was moderately impaired. Review of R109's incident report dated 1/1/2026 revealed Nursing Description: (R109) exited the building at 1855 (6:55 PM). The main entrance door alarm was sounding and (R109) was outside sitting on the sidewalk between the main entrance and the office entrance. (R109) was wearing a brown winter coat backwards covering the front of her body with her arms in the sleeves, winter boots, and pajama pants. Resident Description: they let me outside when asked who let you outside, she stated I don't know I went outside and sat on the sidewalk to the right of the door, smoked my cigarette and came back in. Was this incident witnessed: N (No). Immediate Action Taken: Description: . (R109) educated. Staff educated on the door alarm procedure. Skin Assessment performed. No s/sx (signs/symptoms) of injury, bruising, redness, or skin impairments noted. (R109) exhibited no s/sx of psychosocial distress. Psychosocial needs remain at baseline. Activity Aide (AA) KKK's statement communicated to previous Director of Nursing (DON) revealed that AA KKK turned off the alarm and a resident (Resident #120) told her that R109 set off the alarm then she notified Licensed Practical Nurse (LPN) PP. LPN PP's statement communicated to previous DON revealed that he told AA KKK he would keep an eye on R109 when she was outside smoking her cigarette and then she came inside soon afterwards. LPN PP also stated to the previous DON that he was aware of (R109) going outside on previous occasions. During an interview on 2/5/2026 at 4:16 PM, R109 stated that she goes out of the building to smoke with Resident #47's (R47's) daughter when she visits. R109 said she didn't leave the building on 1/1/2026 to smoke by herself. During an interview on 2/5/2026 at 3:04 PM, R109 Guardian (G) BBB stated that R109 can smoke outside with R47's daughter or a staff member but not by herself. G BBB stated R109's facesheet should show who she was able to go out with. Review of R109's facesheet revealed Special Instructions.(R109) is allowed to go outside and leave facility with (R47's daughter) or (Senior Services staff name omitted) only per her guardian. Review of the interdisciplinary documentation progress note dated 10/13/2025 revealed SS attempted to provide a support visit with resident this morning. SS discussed reports of smoking in courtyard reported by other residents. SS reminded this resident that she is allowed to go with (senior services staff name omitted) . Review of the Wandering Risk assessment dated [DATE] revealed .Assessment Summary: (R109) is not a wandering risk, she does wear a wander guard (wearable electronic tag to monitor movement (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and can trigger alarms when a resident enters a restricted area) to alert staff if she is attempting to exit the building. She is a smoker and wants to go outdoors and smoke in unsafe undesignated areas. (R109) moves about with purpose and a destination. Review of the interdisciplinary documentation progress note dated 1/2/2026 completed by Social Worker (SW) XX revealed SS (Social Services) met with resident several times this morning in regards to behaviors. SS attempted to discuss resident's continuation of exit seeking and going outside to smoke. Resident denied smoking in over a month. SS told by staff that resident was outside smoking last night. Review of R109's active physician orders revealed Exit seeking prevention transmitter (wander guard) check placement q (every) shift. Every shift for exit seeking, placed under the seat of her wheelchair. Active 1/16/2026. Exit Seeking Transmitter Device: Check Function q afternoon shift, if no positive result; replace transmitter. every evening shift for Exit Seeking. Active 7/10/2025. Review of R109's care plan revealed .Focus: Altered functional mobility. Interventions/ Tasks.Exit Seeking Alert: Exit seeking alarm band protection device applied; follow guideline for placement and function on the treatment administration record. Placed under the seat of her wheelchair. Date initiated 7/10/2025. Revision on 1/16/2026.Psychological/Trauma Informed Care interventions: .(R109's) court appointed guardian is responsible for (R109's) safety outside of the facility and will need to approve anyone that (R109) is able to go on LOA (leave of absence) with (R109's) guardian has approved (Resident #47's daughter) as the only person that (R109) may go out of the facility or LOA with (Resident 47's daughter) must notify floor nurse and sign (R109) in and out of the kiosk every time.Date initiated 6/4/2025. Revised on 12/29/2025. During an interview on 2/5/2026 at 12:58 PM, NHA A' stated that R109 wants to go outside unsupervised for smoking and she wasn't safe to do that. NHA A said that R109 snuck out with another resident on 1/1/2026 and was by the activity window and AA KKK saw her the whole time. During an interview on 2/5/2026 at 4:01 PM, AA KKK stated that she didn't know R109 left the building and went outside to smoke until Resident #120 told her when he came back inside from smoking. AA KKK said that when she found out that R109 was outside by herself, she yelled for LPN PP to get R109 from outside because she was doing an activity with residents. AA KKK' stated that LPN PP said he would keep an eye on R109 and for her to go back to the activity. Then, AA KKK said she saw R109 coming back inside and wasn't sure how she came back in the building. AA KKK reported that she told Activity Director (AD) F about R109 leaving the building the next day on 1/2/2026. AA KKK stated that she was written up by the previous Director of Nursing (DON) for not following the policy and responding to the alarm when R109 went outside. During an interview on 2/6/2026 at 8:39 AM, LPN PP stated he was down the hall passing medications when AA KKK told him that R109 was outside smoking by herself. AA KKK told him that she couldn't leave the residents in the activity, so LPN PP said he kept an eye on her from inside. LPN 'PP reported that he continued to pass medications and could see R109 through the window smoking outside. LPN PP stated that he did not see R109 leave the building but saw her come back in. LPN PP also said that he did not report the incident to NHA A or the DON at the time because he didn't think it was a concern since she had gone out to smoke before. LPN PP reported that he wasn't written up by the previous DON, she just spoke to him about responding to alarms and following the policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/2026 at 12:46 PM, Housekeeper (H) HH stated on 1/1/2026 she turned off the alarm to let R109 back into the facility when R109 was done smoking. H HH said she did not see R109 leave the building. During an interview on 2/6/2026 at 8:24 AM, AD F stated that AA KKK was written up for not following the elopement policy and responding to the alarm. AD F said AA KKK notified her the next day on 1/2/2026 about the incident and then she (AD F) reported it to NHA A. During an interview on 2/6/2026 at 8:54 AM, Clinical Care Coordinator (CCC) CC stated that R109 had a wander guard since 7/10/2025 due to exit seeking behavior and wanting to leave the facility to smoke. CCCCC said they tried a wander guard on R109 but she ended up cutting them off and flushing it down the toilet so they put the wander guard under her wheelchair. CCC CC stated that R109 cannot go outside by herself. During an interview on 2/6/2026 at 9:13 AM, Social Worker (SW) XX stated that R109 can't go outside by herself to smoke and her facesheet had instructions on who can take her out to smoke. SW XX reported that staff knew she was an elopement risk since her picture was in the staff break room and in the elopement books at all the nurses' stations. Also, SW XX stated that she had a wander guard to alert staff when she tried to leave the facility. During another interview on 2/06/2026 at 12:56 PM with NHA A, it was discussed that staff did not see R109 leave the building and left her outside to continue smoking and NHA A said she was not aware of that. NHA A reported that that the previous DON notified her about the elopement the next day on 1/2/2026 at 12:38 PM. Review of the Wandering Residents Exit Seeking Management Policy with a revision date of January 2023 revealed .Elopement: The resident's leaving of the facility without staff observation or knowledge of departure.3. Response to a sounding alarm: a. Check the alarm panel to determine which door has been triggered. Do not assume someone else has already done this. B. Check the exit door for any exiting resident by means of a visual check. A visual check means observing the area around the exit and may require leaving the building and checking the grounds. C. If an exit door alarm is triggered, the cause is evaluated and reset after the resident is redirected and their safety is assured. Resident #32 Review of an admission Record revealed Resident # 32 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Parkinson's disease (a progressive, incurable neurodegenerative(gradual dysfunction and death of neurons in the brain) disorder of the central nervous system primarily affecting movements, causing tremors and balance issues), muscle weakness and dementia (an umbrella term for a progressive decline in cognitive function). Review of a Minimum Data Set (MDS) assessment for Resident #32 with a reference date of 1/27/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 13/15, which indicated the resident was cognitively intact. Section GG of the MDS revealed Resident #32 required moderate assistance (helper does less than half the effort) to transfer from sitting to standing and walking 10' was not attempted due to his medical condition or safety concerns. Review of a Care Plan for Resident #32 with a reference date of 8/6/25 revealed the following focus/goal/interventions: (Resident #32) has an actual deficit in ADLs (activities of daily living). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: (Resident #32's) stated goal is to remain in long-term while has (sic) individualized interventions that.accentuate his functional ability. Interventions: FALL-RISK MANAGEMENT: encourage non-skid footwear.keep personal items in reach.floor mat at bedside. (nonslip material brand name omitted) to wheelchair. During an observation on 2/4/26 at 3:20pm, Resident #32 was lying on his back in bed, no fall mat was on the floor next to him. During an observation on 2/5/26 at 10:22am, Resident #32 was observed standing alone by his closet, wearing regular socks and no shoes. A staff member passed by the room but did not stop to offer Resident #32 assistance or to encourage him to put on his shoes. During an observation on 2/5/26 at 12:43pm, Resident #32 slept in his bed, no fall mat was on the floor next to his bed. No nonslip material was present on his wheelchair. During an observation on 2/6/26 at 12:33pm, Resident #32 sat partially upright in his bed with one foot off the bed. No fall mat was on the floor next to his bed. No nonslip material was present in his wheelchair. In an interview on 2/10/26 at 11:06am, Clinical Care Coordinator/Registered Nurse (CCC/RN) CC reported Resident #32 was a fall risk and should have a fall mat on the floor parallel to his bed anytime he was in bed, and non-slip material on his wheelchair seat. In an interview on 2/10/26 Licensed Practical Nurse (LPN) RRR reported on 2/7/26 at approximately 3:30am, Resident #32 was found lying face down on his floor with his head facing his closet. Resident #32 told LPN RRR he was trying to clean out his closet. LPN RRR reported Resident #32 had been more confused that night. LPN RRR reported the fall mat was appropriately placed on the floor next to his bed, the nonstick material was on the seat of his wheelchair and Resident #32 was last seen lying in his bed. LPN RRR confirmed no new interventions were implemented despite Resident #32's increased confusion that night. LPN RRR reported Resident #32 sustained a hematoma (localized collection of pooling or mostly clotted blood trapped in tissue) to his L forehead from the fall and was sent to local emergency department for further evaluation. Review of an After Visit Summary for Resident #32, (local hospital name omitted) with a reference date of 2/7/26 revealed Reason for visit: fall. Diagnoses: Ground-level fall, hematoma of frontal scalp, initial encounter, Tremor of both hands.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain sufficient hydration and consistent nutritional status monitoring and re-evaluation by a nutrition professional of residents at risk for altered hydration and nutritional status for 3 of 4 residents (Resident #18, #98, #32) reviewed for hydration/nutrition resulting in the potential for dehydration, weight loss, and unmet resident needs.Findings include: Resident #18: Review of an admission Record revealed Resident #18 was a female with pertinent diagnoses which included diabetes, paralysis left side, stoke, dementia, need for assistance with personal care, and stroke. Review of Care Plan for Resident #18 revised on 1/7/25, revealed the focus, .(Resident #18) has the potential for an altered nutritional status primarily related to her diagnoses of dementia and type 2 DM (diabetes). This may lead to diminished cures of hunger or thirst and a decreased understanding of the importance of eating as well as altered blood sugars. with the intervention .Evaluate laboratory values in relation to nutritional needs prn (as needed).Nutritional Supplements per Dietary Assessment.Refer to ADL flow sheet for diet specifications.Registered Dietician evaluation prn. Review of Lab results dated 11/24/25, indicated Resident #18's sodium was high at 147, normal range 135-145 mmol/L, creatinine was high at 1.22 normal range .50-1.00 mg/dL, eGFR (estimated glomerular filtration rate) was low at 44, normal range >60 mL/min/1.73m2, Blood urea nitrogen (BUN) was high at 37, normal range 8-23 mg/dL . Note: All of these results were indicative of dehydration. Review of Interdisciplinary Documentation dated 10/28/2025 at 2:08 PM, .It was reported that (Resident #18) was having urinary complaints with burning with urination and increased noted behaviors. HCP (Health Care Provider) notified and order UA (urinalysis) with C&S (culture & sensitivity) if indication. UA completed revealed >=100,000CFU/ml E Coli meeting criteria for ABT (antibiotic) treatment. HCP notified and ordered treatment with Cephalexin 500mg TID (three times a day) x7days. Medications reviewed for any potential medication interactions. No adverse reactions noted so far throughout course of treatment. Routine toileting with proper peri care and hand hygiene continued. Increased oral fluids encouraged. STCP in place for continued staff monitoring. During an observation on 02/04/2026 at 11:35 AM, Resident #18 was in the hallway, no cup holder noted on her wheelchair, was attempting to enter another resident's room and was redirected by staff to head to the dining room for lunch. During an observation on 02/04/26 at 12:00 PM, Resident #18 was not in her room, Styrofoam cup with lid and straw was located on the nightstand, it was full. T` During an observation on 02/10/2026 at 9:42 AM, Resident #18 had water in her room, no ice in the cup. Resident #18 had not drunk any of her water. During an observation on 02/10/2026 at 9:56 AM, Resident #18 was seated in her wheelchair at a table in the dining room, she had her eyes closed and she did not have any fluids in front of her. During an observation on 02/10/2026 12:09 PM Resident #18's water was full and was the same sytrofoam cup as earlier in the day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/10/2026 12:32 PM Resident #18 was seated at the dining room table and she had not touched her coffee, chicken with sauce, or her creamed corn. During an observation on 02/10/2026 at 12:43 PM Resident #18 was eating some noodles by using her hand and was trying to pick up the sauce by hand as well. No staff were observed providing encouragement to eat or drink. Utensils were under her napkin which was folded in half over the top of the utensils. During an observation on 02/10/2026 at 12:53 PM, Resident #18 had not picked up her coffee to drink, there was no water or any other juice on the table. Resident #18 picked up the chicken breast by hand and ate the sauce from it but not the chicken and then she was using her hands to eat the creamed corn in a small saucer type bowl. Review of Resident #18's medical record revealed the last Nutritional Assessment completed for her was 1/7/2025. In an interview on 02/10/2026 at 10:03 AM, CNA Z reported the CNAs would only document fluid and meal intake for certain people who were flagged to document on, and the nurse would be able to document as well. CNA Z reported fluid intake was not tracked. CNA Z reported the activities department supervised the main dining room and would log the food and fluid intake of the residents. During an observation on 02/10/2026 at 12:59 PM, Resident #18 picked up her cup of coffee, and struggled to bring it to her lips to take a drink. Resident #18's hands were shaking and the coffee was spilling from her mouth and down the front of her shirt. Resident #18 did not attempt to drink anymore coffee, did not finish her meal ate only a few bites of the chicken breast, left most of the creamed corn and half of the serving of noodles were left on her plate. In an interview on 02/10/2026 at 12:18 PM, Licensed Practical Nurse (LPN) LL reported the nurse would review the lab results, place the report in the doctor's book or if necessary, contact the provider. LPN LL reported the provider would review and initial the lab was reviewed. For Resident #18 she reviewed the lab for the urinalysis, entered the order or have us put in the order and sign off on the order for the antibiotic. LPN LL reported after review of the lab results, the provider would do a repeat of the lab. LPN LL reported that if a resident needed staff to review and document their fluid intake, the clinical care coordinator could place an order in the resident's chart for staff to complete this task in the CNA charting. Review of Dietary Orientation received on 2/6/26, revealed, .Monitoring Fluid Intake & Hydration Needs: Visually observe for fluid intake. Water is passed twice a day. Encourage residents to take sips throughout the day. The feeling of thirst decreases as we age, dehydration is a huge risk to the elderly. In an interview on 02/10/2026 at 1:01 PM, Clinical Care Coordinator (CCC) AA reported when labs were drawn, they were reviewed and discussed for what interventions would come next, if necessary. CCC AA reported the provider would review, initial and either verbally speak with the nurse or place orders themselves. CCC AA reported staff members monitor fluid intake for all residents and encourage intake for residents except those who were on fluid restriction. CCC AA reported the staff members who monitor the dining room would communicate to the nursing staff any concerns with resident intake of fluids and the nursing staff would monitor the residents output. CCC AA reported if a resident had labs with high sodium, high creatinine, low eGFR (estimated glomerular filtration rate), (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	high Blood urea nitrogen the facility would recheck the labs to ensure the results were still abnormal. This writer requested additional lab work completed following the lab results from 11/24/25. In an interview on 02/10/2026 at 10:07 AM, Registered Dietician (RD EEE reported she was a consultant, and the facility would contact her if they had any questions on dietary needs for residents. RD EEE reported she assisted with nutritional assessments which were done at admission and annually unless there was a need to trigger one any other time, like with a significant change. RD EEE reported she did not review lab work completed on the residents in the facility, she only reviewed if she was alerted by the physician to review. RD EEE reported she depended on nursing staff to report concerns to her for a resident's intake as she was not in the facility every day, so it was the facility's responsibility to monitor and report concerns to her. RD EEE reported Resident #18 who had lab work with abnormal levels, was a diabetic, had history of urinary trach infections, and had a dementia diagnosis, the facility should be encouraging fluid intake as those factors could indicate the resident was not drinking enough and needed closer monitoring of fluid intake. Note: No other lab results were provided prior to exit from the facility. Resident # 98 (R98) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R98 admitted to the facility on [DATE] with pertinent diagnoses including dementia (decline in cognitive abilities severe enough to interfere with activities of daily life) and umbilical hernia (soft bulge near belly button caused by abdominal contents pushing through weakness in abdominal wall). Brief Interview for Mental Status (BIMS) reflected a score of 3 out of 15 which indicated R98 was severely cognitively impaired. During an observation and interview on 2/5/2026 at 9:00 AM, R98 was feeding himself in the small dining room and was unable to hold a conversation due to his cognition. Review of R98's care plan revealed Focus: Potential risk factors for nutritional concerns include: umbilical hernia, dementia with confusion which may progress and affect his ability to know hunger and thirst.Interventions/Tasks.Evaluate significant change with routine weights. Date initiated 7/22/2025. Review of R98's food acceptance record (FAR) for the last 30 days revealed no documentation between 1/20/2026 to 2/4/2026 which was 16 days. Review of R98's weight record revealed on 1/4/2026 R98 weighed 173.5 lbs (pounds). On 01/29/2026, R98 weighed 164 lbs which was a 5.48% (percent) weight loss. No other weights were obtained from 1/29/2026 until 2/5/2026 after entrance for survey. Review of R98's last nutrition assessment completed 8/10/2025 revealed (R98) is triggering for weight loss with his last weight listed above at 168# (pounds). His weight per record review in May 2025 was 146#. He was in the hospital at that time. He was homeless and may not have had adequate nutritional opportunities. Per his BMI he is at a healthy weight. He was on FAR (Food Acceptance Record) for over 30 days with 100% intake. No current open areas. He does have Dementia which could eventually be a factor with food acceptance as the disease progresses. Will continue to monitor weights for trends and intervene as applicable. MST (malnutrition nutrition screen) not completed as assess (assessment) was completed remotely. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Interdisciplinary Documentation completed by Registered Dietitian (RD) on 1/19/2026 revealed Review of weights for (R98) currently reflects a weight loss, however overall weight has been slowly increasing. Weight loss occurred between 10/12 and 10/26, since then weight has been slowly increasing. FAR reflects excellent intake at meals 100%. Goal is for a slow weight gain. Continue current plan of care. Review of Interdisciplinary Documentation 2/2/2026 revealed (R98) has not been eating well lately. CNA (Certified Nursing Assistant) observed decreased appetite and when questioned, (R98) did admit to having mouth pain. LPN placed order request to have patient have dental appointment and downgrade meals to mechanical soft until oral pain resolved. Review of active physician orders revealed General diet, Mechanical Soft texture, Thin consistency for new onset oral pain. Active 2/2/2026. Nutritional Supplement prn (as needed). No directions specified for order. Active 7/10/2025. Nutrition supplement 90 cc (90 ml-milliliters) tid (three times a day) and weight every day for 3 days were started on 2/6/2026 during the survey. During an interview on 2/5/2026 at 1:33 PM, Registered Dietitian (RD) EEE stated that she came to the facility every other week. When discussing weight changes with residents, RD EEE said since she wasn't in the building very often so the CNAs (Certified Nursing Assistants) and CCCs (Clinical Care Coordinators) put interventions in place for weight changes and then they call her if concerns arise. RD EEE stated that R98 had weight fluctuations since admission and wasn't on a diuretic. RD EEE also stated that they don't have anything about reweights in their policy and how often they need it get a reweight with a significant weight loss or gain. When discussing the last nutrition assessment that was completed on 8/10/2025, RD EEE reported that they are only required to do a nutrition assessment once a year as long as the MDS is completed quarterly. RD EEE stated that the CCC should monitor weights and ask for reweights and send that information to Director of Nursing (DON) B. During an interview on 2/5/2026 at 1:55 PM CCC CC stated that when there was a weight discrepancy (5 pounds), they would get a reweight for a couple of days to make sure the weight change was accurate. For weight losses, CCC CC stated a nutritional supplement would be started. During another interview on 2/6/2026 at 12:28 PM, CCC CC stated that they have weight monitoring meetings where RD EEE looked at resident weights remotely and emailed the Dietary Manager (DM) to bring any concerns to the meeting, but she said this hasn't been happening due to the turnover in the kitchen. During an interview on 2/05/2026 at 1:50 PM DON B stated that weights were taken with showers and the nurse verifies if there was a discrepancy and would ask for a reweights if there was one. DON B verified that R98 had a significant weight loss and there wasn't a reweight done from 1/29/2026 to 2/5/2026. DON B stated she wasn't sure what the policy for weights was and CCCs keep track of their units and she tries to monitor the dashboard. DON B also reported that RD EEE looks at weights remotely and sends emails with reweights and recommendations for residents. Review of the Weight Management Policy with a revision date of April 2025 revealed .5. In the event of a patterned or significant unplanned weight loss/gain the IDT (interdisciplinary team) is responsible for assessing and implementing individualized interventions. a. Parameters for evaluating significance of unplanned and undesired weight loss/gain are.5% in 30 days, 7.5% in 90 days, 10% in 180 days. Resident #32 Review of an admission Record revealed Resident # 32 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: parkinson's disease (a progressive, incurable neurodegenerative(gradual dysfunction and death of neurons in the brain) disorder of the central nervous system primarily affecting movements, causing tremors and balance issues), muscle (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weakness, and dementia (an umbrella term for a progressive decline in cognitive function). Review of a Minimum Data Set (MDS) assessment for Resident #32 with a reference date of 1/27/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 13/15, which indicated the resident was cognitively intact. Review of a Care Plan for Resident #32 with a reference date of 1/29/25 revealed the following focus/goal/interventions: (Resident #32) is at risk for altered nutrition due to conditions associated with dysphagia (swallowing difficulty), dementia, tremor.Goal: 1. Reduction in risk of factors for hypo-hyperglycemic events (excessively high or how blood sugar level) 2. Weights will remain stable. Appropriate interventions will be placed as needed. Interventions. Adaptive equipment: large soup spoon. evaluate significant weight change with routine weights. serve diet as ordered. Review of Physician Orders for Resident #32 revealed Weight three times weekly in the morning, every Monday, Wednesday, Friday with a start date of 11/12/25. Review of a Weight Summary record for Resident #32 revealed his weights were documented 25 of 37 opportunities during the twelve-week period of 11/12/25-2/2/26. Review of a Weights task report for Resident #32 revealed the resident had not refused being weighed in the last 30 days. A task report for the last 60 days was requested but not received at the conclusion of the survey. In an interview on 2/4/26 at 3:14pm, Resident #32 reported he was concerned about the amount of weight he had lost in the past year. Resident #32 reported he had difficulty feeding himself at times when the staff didn't provide enough set up assistance and he didn't receive the large spoons he needed to feed himself. Resident #32 stated I'm skinny compared to what I used to be. Resident #32 reported he provided his own nutritional drinks now because he felt he could not consume enough calories during meals. Review of an Interdisciplinary Progress Note for Resident #32 with a reference date of 2/1/25 revealed (Resident #32 name omitted) current body weight is 160lbs (pounds).Dietary Manager will continue to monitor weights. Review of a Nutritional Assessment for Resident #32 with a reference date of 10/29/25 revealed .most recent weight 141.0 (pounds).

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pre-dialysis assessments were completed for 1 (Resident #19) of 4 residents reviewed for dialysis services, resulting in the potential for miscommunication, inadequate documentation of resident's clinical conditions, and unmet care needs. Findings include: Resident #19Review of an admission Record revealed Resident #19 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and end stage renal disease (final stage of chronic kidney disease, where the kidneys can no longer function adequately to sustain life without treatment). Review of Resident #19's Care Plan revealed, Focus: Hemodialysis required to remove urea & other toxic products from the blood: At risk for loss of vascular access; clotting, hemorrhage(bleeding), infection. At risk for exacerbation of heart failure with inadequate dialysis or increased hypervolemia (fluid overload). Date Initiated: 10/14/2025. Interventions: Assess fluid volume excess as indicated for signs and symptoms (routinely completed at dialysis as well); routine weights; JVD (Jugular vein distention-is a medical condition characterized by the bulging of the jugular veins in the neck); breath sounds; peripheral and sacral edema (swelling) assessments. Date Initiated: 10/14/2025. Assess reports of pain and or numbness distal to access site. Date Initiated: 10/14/2025. Establish communication with dialysis center process of communication is asfollows: Communication sheet sent with (Resident #19) to Dialysis center on each dialysis day, and Dialysis center should send back with (Resident #19)on his return to the facility, and then the sheet is uploaded into (Resident #19's) documents in his chart. Date Initiated: 10/14/2025 .Review of Resident #19's Hemodialysis Communication Forms revealed that nursing staff had not documented the completion of a pre-dialysis Assessment on the following dates: 11/21/25, 11/23/25, 12/1/25, 12/20/25, 1/14/26, 1/26/26, and 2/6/26. During an interview on 2/6/2026 at 1:48 PM, Licensed Practical Nurse (LPN) PP reported nursing staff were responsible for ensuring that a resident was assessed prior to leaving the facility for dialysis. LPN PP reported that the nurse should assess the resident's fistula site and obtain pre-dialysis weight and vital signs. LPN PP reported that nurses were supposed to document the pre-dialysis assessment on the hemodialysis communication form and send that form to the dialysis facility. LPN PP confirmed that the facility nursing staff primarily communicated about resident's health condition via the dialysis communication form. During an interview on 2/10/2026 at 11:57 AM, Clinical Care Coordinator (CCC) CC reported that every resident that received dialysis at the facility was supposed to be assessed prior to leaving for dialysis, and that the nurses were responsible for documenting the assessment on the hemodialysis communication form and sending the form with the resident to the dialysis facility. CCC CC reported that the communication forms needed to be completed and reviewed by nursing staff to ensure the staff were aware of any changes in Resident #19's condition or dialysis treatment orders. CCC CC reviewed Resident #19's Hemodialysis Communication Forms with this writer and confirmed that nursing staff had not documented the completion of a pre-dialysis Assessment on the following dates: 11/21/25, 11/23/25, 12/1/25, 12/20/25, and 1/26/26, and 2/6/26. CCC CC reported that she was aware that nursing staff were frequently missing pre-dialysis assessments, and that she had talked to the nurses about the importance of completing the hemodialysis forms recently. CCC CC reported that Resident #19 would sometimes refuse to go his dialysis appointments, but that nurses should document the refusal of dialysis appointments on Resident #19's Hemodialysis communication form. During an interview on 2/10/2026 at 12:12 PM, Medical Records (MR) ZZ reported she was responsible for appointment scheduling and tracking missed appointments for the residents at the facility. MR ZZ confirmed that she had record that Resident #19 had refused to go to dialysis on 1/7/26, 1/14/26, and 1/23/26 and 2/9/26. Review of the facility's Dialysis policy dated 2021 revealed, Policy: It is the policy of this facility to assist in and arrange for dialysis facility services as available for residents' requiring dialysis with a diagnosis of end-stage renal disease. Purpose: To (continued on next page)

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	235594	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Niles	1211 State Line Rd Niles, MI 49120

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide general guidance for communication and continuum of care for a resident requiring dialysis services at an external dialysis facility . Procedure: 1. Arrangements with dialysis facilities for the provision of dialysis services will be established upon admission and as needed. Residents who require dialysis services will be provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 2. Ongoing provision of assessment, care planning and provision of care with the dialysis facility will be in collaboration with facility services. Communication tools, short term care plans and assessment collaboration with medical and nutritional services will be ongoing for the continuum of care .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician documented review of pharmacy recommendations timely for 1 resident (Resident #5) of 6 residents reviewed for unnecessary medications resulting in the potential for medication side effects to occur and/or unnecessary medications for residents.Findings include:Resident #5 (R5)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R5's initial admission date was 10/30/2023 with pertinent diagnoses including depression, delusions (delusions are false beliefs that persist despite evidence to the contrary), bipolar disorder (intense mood swings ranging from extreme highs and lows), dementia (decline in cognitive abilities severe enough to interfere with activities of daily life) and chronic pain. Brief Interview for Mental Status (BIMS) reflected a score of 10 out of 15 which indicated R5 cognition was moderately impaired. Review of R5's active physician orders revealed Olanzapine (Zyprexa, antipsychotic medication to treat bipolar disorder) oral tablet 5 mg. Give 1 tablet by mouth one time a day for bipolar disorder.Zoloft (sertraline, antidepressant) oral tablet 50 mg tablet by mouth one time a day for major depressive disorder.Review of R5's monthly pharmacy review dated 9/10/2025 revealed .Resident is taking olanzapine and is at increased risk of weight gain and decreased effectiveness . monitor for adverse effects and adjust (dosage) accordingly.Recommendations: Please consider changing therapy to one of the listed alternatives (Paliperidone-antipsychotic drug used to treat schizophrenia, quetiapine-antipsychotic to treat schizophrenia, bipolar and other depressive disorders, , ziprasidone-antipsychotic to treat certain mental and mood disorders) to ensure resident is not having adverse effects from therapy. The recommendation was signed in agreement by the physician on 2/10/2026 (day of survey exit). Another pharmacy recommendation for R5 from 9/10/2025 revealed Resident is taking sertraline and at increased risk of side effects (nausea, diarrhea, insomnia (difficulty sleeping) and sexual dysfunction) and decreased effectiveness. Initiate therapy with recommended starting dose and consider a slower titration schedule and lower maintenance dose.monitor for clinical efficacy and adjust dose accordingly. Recommendation: Please consider changing sertraline to one of the listed alternatives (fluvoxamine-used to treat obsessive compulsive disorder, vortioxetine-antidepressant) to ensure resident is getting the most benefit and least adverse effects from therapy. The recommendation was signed in agreement by the physician on 2/10/2026 (day of survey exit). Review of R5's monthly pharmacy review dated 10/12/2025 revealed Resident has 2 orders for calcium carbonate. Please discontinue one of the orders if it is a duplicate. The recommendation was signed in agreement by the physician on 2/9/2026 (during the survey). During an interview on 2/10/2026 at 12:04 PM, Director of Nursing (DON) B stated that the pharmacist completes monthly pharmacy reviews and sends recommendations to her and then she prints them out and puts it in the physician/provider mailbox. DON B said that once the physician signs the recommendation and notes whether they agree or disagree with the pharmacy recommendations, it was returned to the DON mailbox and changes were made in the resident's chart if indicated. DON B was unsure of how the pharmacy recommendations records were maintained prior to her assuming the position of DON, and she was unable to locate R5's previous pharmacy recommendations. Corporate RN (CRN) GGG obtained copies of previous recommendations and provided them to the physician for review on 2/9/2026 and 2/10/2026. Review of the Medication Monitoring Policy with an effective date of 10/1/2018 revealed Procedure.7. For non-urgent recommendations, the Facility and Attending Physician must address the recommendations in a timely manner that meets the needs of the resident- but no later than their next routine visit to assess the resident- and the Attending Physician should document in the medical record: a. What irregularity has been reviewed. B. What action has been taken to address the issue. C. The pharmacy recommendation itself can be used as a tool to (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document in the medical record, or a notation may be indicated in the medical record/EHR (electronic health record) .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure 1 (Resident #114) resident of 6 reviewed for unnecessary medications was prescribed a controlled medication, resulting in the use of a controlled addictive substance without adequate diagnosis or indications of use with potential for adverse side effects including negative physical and psychosocial side effects. Findings include: .Use of Adderall can create psychological dependence, physiological dependence, and tolerance may occur with amphetamine; dextroamphetamine therapy. Abrupt discontinuation or a significant dose reduction of CNS (central nervous system) stimulants after prolonged use may produce withdrawal symptoms that include dysphoria, depression, fatigue, vivid and unpleasant dreams, insomnia or hypersomnia, increased appetite, and psychomotor retardation or agitation. Signs and symptoms of chronic amphetamine abuse include severe dermatoses (skin defect or lesion of the skin), marked insomnia, irritability, hyperactivity, personality changes, and psychosis with features indiscriminate from schizophrenia. https://www.merckmanuals.com/professional/drug-names-generic-and-brandResident #114: Review of an admission Record revealed Resident #114 was a male with pertinent diagnoses which included multiple sclerosis (the body's immune system attacks the protective covering of the nerve cells in the brain and spinal cord, disrupting signal transmission), need for assistance with personal care, suprapubic catheter (thin, flexible tube inserted through a small incision in the lower abdomen directly into the bladder to drain urine), muscle wasting and atrophy multiple sites (loss of muscle tissue characterized by decreased size, strength, and function), depression, anxiety, and chronic pain. Review of Order dated 9/4/25 for Resident #114, revealed, .Adderall Oral Tablet 20 MG (Amphetamine-Dextroamphetamine) .Give 1 tablet by mouth two times a day for ADHD. Review of Resident #114's medical record revealed no diagnosis of ADHD (attention deficit hyperactivity disorder). Review of current Care Plan for Resident #114, revised on 12/12/25, revealed the focus, .(Resident #1140 has the potential for psychosocial distress related to: expressing sadness / anger / empty feeling over lost roles and status. with the intervention .He easily becomes frustrated and agitated and is receptive to (Behavioral Health Services Provider) services that are in place. (Resident #114) expresses himself by using profanity. He has been educated that smoking and vaping is not allowed on the facility property.Acknowledge residents mood and behavior; conveying acceptance toward the resident while rejecting negative behavior.Allow time and opportunities to express feelings.Assess feelings or behaviors that could present a danger to self or others and intervene accordingly.Behavior monitoring as identified on the individualized log; utilize log for patterning and intervention revision as indicated.Evaluate changes in mood and socialization.Identify behavioral precipitants if possible to assist with further defining effective dementia care and trauma informed care.Maintain a calm environment as able.Respond to the emotional content of what the resident is saying by utilizing distraction techniques vs reasoning which can escalate behavior. Review of HCP (Health Care Provider) Visit dated 11/6/25, revealed, .CC: Shingles rash, agitation, use of marijuana.Hoping to have a discussion on safety of using both Adderall and marijuana. 3 marijuana edibles in his bed and empty packages on the floor were found in his room by his nurse. He does admit to the nurse finding them and states that nurse Licensed Practical Nurse (LPN) PP) is an asshole for telling on me. He also explains he is unhappy about his living situation at this facility and that this place stresses me out, this is why I have this rash; I'm not talking about this with you right now, we can talk about it in court. Asked if he is unhappy and stressed why he does not work with (Community Based organization) and social work to find new care facility or AFC (Adult [NAME] Care). His response is no one will take me. He became irritated when attempting to discuss Adderall use and said, you can't even talk to me because I need higher level of care for my advanced MS (multiple sclerosis), you're just a nurse practitioner. When offered to have him see (Medical Director D) he states, he's just a nursing home doctor, I don't want him either. Explained he did have the right (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to find his own PCP (Primary Care Provider) and he repeated he needs a higher level of provider due to his MS but denied having a neurologist that he saw prior to coming to facility .He became increasingly agitated.GEN: agitated.Will decrease use of Adderall to once daily due to increased agitation with most staff and labile mood (rapid, intense and often uncontrollable shifts in emotional state), used in prior notes for fatigue due to MS but seems counterproductive when using in combination with Marijuana. Discussed with management that patient may find appropriate level of care he feels is better suited to manage his medical needs. MS-Recommend follow up with neurologist, was seen by (Medical Doctor) in past was on Tecfidera and Ocrevus in past. Was seen by (Medical Doctor) for 2nd opinion (1/19/2019) but note review did reveal he became agitated when (Medical Doctor) would not prescribe opiate medications and referred him back to previous neurologist. His last appointment able to view was 2/5/2019 with (Medical Doctor) .Review of Psychiatry Progress Note dated 11/12/2025, revealed, .Clinical Update -11/12/2025: The resident was reviewed during the Behavior Management Meeting with input from Social Services, MDS (Nurse who manages the Medicare/Medicaid mandated assessment process), and Nursing .He appeared mildly anxious but pleasant during observation .The resident was counseled regarding his current ADHD medications, as his presentation does not meet diagnostic criteria and behavioral therapy is more appropriate. Discussion was held regarding the need to gradually wean off stimulant medication. The resident was hesitant about this recommendation, stating that he had been diagnosed by neurology. Staff also reported that the primary care provider had already begun a gradual taper, reducing the dose to once daily. Psychotherapy was recommended to provide additional emotional support and assist with behavioral regulation. Nursing staff are advised to continue monitoring for clinically significant changes in mood and behavior, including: Depression: sadness, tearfulness, social withdrawal Anxiety: irritability, excessive worrying .Due to concerns regarding possible substance use disorder, initiation of additional psychotropic medication will be deferred. Review of Order dated 11/12/25 for Resident #114, revealed, .Adderall Oral Tablet 20 MG (Amphetamine-Dextroamphetamine) .Give 1 tablet by mouth two times a day for MS and Chronic Fatigue. Review of Interdisciplinary (IDT) Documentation dated 11/18/2025 11:47 AM, .(Resident #114) admitted to facility with Rx (prescription) of Adderall and no appropriate diagnosis. (Behavioral Health Serviced Provider) services are in place and have been unable to get an appropriate diagnosis code and attempts to reduce to D/c (discontinue) Adderall have failed due to resident's refusal to GDR (gradual dose reduction) .Resident #114 remains his own person. He has agreed to a neurology follow up and plan is for resident to follow up with Neurology and resident would prefer to see his Neurologist that he has used in the past. Scheduler attempting to schedule with his Neurologist at this time.Review of Quarterly MDS Assessment IDT Note dated 12/16/25 at 1:15 PM, .He is on Adderall which he states he has taken for at least 10 years without a proper diagnosis and adamantly refuses to decrease or stop the medication.(Resident #114) has behaviors such as anger specifically stated by him toward life and his current situation frequently lashes out at staff, requires his care to be in pairs. He receives trazadone as needed for sleep and Seroquel for depression . Review of Interdisciplinary Documentation dated 12/17/2025 at 2:42 PM, revealed, .GDR/Behavior/Psychotropic medication review with SS (social services), CCC (clinical care coordinator), DON (Director of nursing).pharmacy recommendations: Meds in review: Currently taking Seroquel, valium, gabapentin, Adderall.He has a neurology appt in January regarding Adderall use which he does not have an appropriate diagnosis. Review of BH (Behavioral Health) Progress Note dated 1/2/26, revealed, .Mental Status Exam: Depressed/Dysphoric/Sad.Anxious/Worried.Agitated.Irritable. Session Summary: In session, resident showed alert. rising and falling irritability, and cooperative.Clinician provided supportive therapy. CBT (cognitive based therapy), and neurocognitive stimulation-based techniques to help explore and promote adaptive management of negative affect.Interactive Complexity: Yes; maladaptive emotional issue that negatively impacted treatment (e.g., tearfulness, high expressed emotions).Review of Interdisciplinary Documentation dated 01/28/2026 at 3:33 PM, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed, . (Resident #114) .This resident unsure why Adderall was started and is currently seen by (Behavioral Health Serviced Provider) and facility MD/NP. Both have recommended D/Cing the Adderall and resident refuses stating that his neurologist recommended. This residentreceptive to following up with neurologist regarding current needs and medications in order to establish appropriateness of medications and any additional/ongoing needs. (Resident #114) is scheduled for neurology follow up on 1/29/2026. (Resident #114) continues to have behaviors of frustration with his limitations, accusatory behaviors, med seeking and self-medicating outside of facility. He remains his own person and is able to leave facility independently for LOA (leave of absence) . In an interview on 02/05/2026 1:24 PM, Social Worker (SW) XX reported Resident #114 was admitted with Adderall prescribed. SW XX reported she had discussed this prescription with (Behavioral health services provider) to determine if they would be able to give him a diagnosis to continue the Adderall, he did have a neurology appointment on 1/29/26 as a follow up for the Adderall use as an agreement from the Nurse Practitioner (NP) to continue until he was able to follow up with the neurologist. SW XX reported Resident #114 was refusing to discontinue the use of the Adderall or discuss it so the agreement was he would stay on it until he was able to meet with neurology. SW XX reported she had not heard the outcome of the appointment on 1/29/26. In an interview on 02/05/2026 2:11 PM, Clinical Care Coordinator (CCC) AA reported the neurologist did not send any paperwork back with him and Medical Records (MR) ZZ sent in a request for the documentation.In an interview on 02/06/2026 11:52 AM, This writer knocked on Resident #114's door to his room and requested to enter and there was no reply even though there was obvious movement in the room. Review of Neurologist Progress Note dated 1/29/26, there was no documented support for the continued use of Adderall for Resident #114. In an interview on 02/05/2026 at 2:41 PM, Nurse Practitioner (NP) MMM reported she felt the Adderall was contributing to his irritability with staff members by the use of profanity, argumentativeness, and emotional outbursts. NP MMM reported Resident #114 did not have an appropriate diagnosis to continue the use of the Adderall and she had attempted to discontinue the Adderall last fall. NP MMM reported she had received a call from the Director of Nursing and the Nurse Manager due to discontinuing the Adderall and his resistance. NP MMM reported she was informed Resident #114 had refused to come off the medication, and he felt she was not qualified to discontinue the medication as she did not feel it was safe for him to continue the medication as he did not have an appropriate diagnosis to support the continued use of it. NP MMM reported she agreed for him to have a follow up with a neurologist to determine his continued use, but she was concerned as Resident #114 had a history of substance abuse and she thought he had developed an addiction to the Adderall. NP MMM reported she had spoken to Medical Director (MD) D, and he had agreed the medication was not appropriate for Resident #114 as well as (Behavioral health services providers) as well.