STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 West Vienna Road Montrose, MI 48457

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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 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 who consume food from the kitchen. Findings include: On 01/27/2026 at 9:00am-9:15am during the initial kitchen tour with Kitchen Manager K observed mixer visibly soiled with accumulated debris. During this observation, Kitchen Manager K was asked how often the mixer is cleaned and stated it's cleaned after every use. On 01/27/2026 at approximately 9:15am-9:30am observed brown and pink residue on the interior walls of the ice machine located in the short-term satellite kitchen. During this observation, Kitchen Manager K was asked how often the ice machine is cleaned and she stated maintenance cleans it every three months. On 01/27/2026 at approximately 9:15am-9:30am observed the rag sanitizer bucket visibly soiled with dark discoloration, located in the short-term satellite kitchen. The rag sanitizer bucket was tested with Sunburst Chemical chlorine test strips and the result was zero. During this observation, Kitchen Manager K was asked how often the sanitizer bucket is changed out and she stated it's changed out after every meal. On 01/27/2026 at approximately 9:30am-9:40am observed the interior ceiling of the microwave visibly soiled, located in the long-term satellite kitchen. During this observation, when Kitchen Manager K was asked how often the microwave is cleaned out, she stated it's cleaned every morning. On 01/27/2026 at approximately 9:30am-9:35am observed the interior wall of the ice machine visibly soiled with brown residue, located in the long-term satellite kitchen. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.According to the facility's policy on kitchen sanitation, All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions.On 01/27/2026 at approximately 9:40am when interviewed on what the desired range is for the rag sanitizer bucket located in the short-term satellite kitchen, Kitchen Manager K stated they want it at 50. When asked what sanitizer solution is used for the rag sanitizer bucket, Kitchen Manager K stated bleach is used. According to the 2022 Food Code, 3-304.14 Wiping Cloths, Use Limitation, Cloths in-use for wiping counters and other equipment surfaces shall be .Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114 and The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit. According to the facility's policy on kitchen sanitation, Sanitizing of environmental surfaces must be performed with one of the following solutions .50-100 ppm chlorine solution. According to the facility's policy on kitchen sanitation, Between uses, cloths and towels used to wipe kitchen surfaces will be soaked in containers filled with approved sanitizing solution. Sanitizing solution will be changed at least once per shift or if (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	solution becomes cloudy or visibly dirty. On 01/27/2026 at approximately 11:30-noon during lunch observation in the short-term satellite kitchen, observed rag sanitizer bucket stored next to drink prep area while drinks were being poured into glassware. During this observation, this surveyor drew attention to the chemicals stored next to the drink prep area and it was removed. When interviewed on where the sanitizer bucket is usually stored at, Kitchen Manager K stated it's usually stored by the hand sink. According to the 2022 Food Code, 7-201.11 Separation, Poisonous or toxic materials shall be stored so they can not contaminate food, equipment, utensils, linens, and single-service and single-use articles by .Separating the poisonous or toxic materials by spacing or partitioning. According to the facility's policy on storage of chemicals, Only chemicals that are required to maintain kitchen sanitation shall be permitted in the pot washing and dishwashing areas but may not be stored or used in the presence of food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has 2 Deficient Practice Statements (DPS). Based on interview and record review, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility. Based on interview and record review, the facility failed to have a comprehensive infection control program for residents residing in the facility Findings include: Resident #15 (R15): According to a review of R15's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to cellulitis (bacterial infection) of the right lower limb, abscess of right lower limb, osteomyelitis (infection of bone),Methicillin Resistant Staphylococcus Aureus (MRSA) infection (bacteria that is resistant to many antibiotics, including methicillin) and has a peripherally inserted central catheter (PICC) and receiving IV Vancomycin (an antimicrobial medication used to treat resistant bacteria) with 6 weeks remaining on IV therapy. R15's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) score of 15/15 that indicated the resident was cognitively intact. Additional medical diagnoses included: Chronic Obstructive Pulmonary Disease (COPD/progressive lung disease) Muscular dystrophy, Hypokalemia (low potassium), and weakness. On 01/27/2026 at 9:46AM, During an initial walk through of the unit an observation of 5 total enhanced barrier precautions (EBP) signs and 2 total transmission-based precautions (TBP) signs were posted on residents' doors. None of the 7 residents or rooms identified included R15.On 01/27/2026 at 10:58 AM, Observation of R15 sitting in wheelchair in his room watching television. There is an IV pole in the room with no IV medication hanging. He has a PICC line in his left upper extremity dated 01/27/2026. R15 is agreeable to interview. R15 said he has been at the facility for about 6 weeks, he said he has a bone infection. And that he had been on IV and oral antibiotics to treat it. When asked if staff wear personal protective equipment (PPE) clarified as gown, gloves and masks when providing IV or wound care, R15 said they wear gloves but no gowns. R15 further explained that earlier that morning (01/27/2026) the nurse changed his PICC site dressing and she wore gloves and no other PPE. On 01/27/2026 at 11:00 AM during an interview, Nurse B she was asked if residents with indwelling lines such as PICC lines should be on EBP, she said yes, those residents required EBP. She was asked if R15 had a PICC line, she said, yes, it was in his left upper arm and he received IV antibiotics. Nurse B was asked to locate the EBP sign posted and the PPE cart for R15's room and she looked at R15's door and stated, it's not there, but should be and Nurse B indicated it would be addressed due to the interview. On 01/28/2026 at 9:20 AM, An observation was made of an EBP sign outside R15's room door and PPE cart inside R15's room. R15 was not in his room. On 01/28/2026 at 2:28 PM, Observed R15 sitting up in his wheelchair watching tv in his room. When R15 was asked if staff were wearing gowns and gloves when changing IV or dressing, he said they had brought the cart to his room this morning (R15 pointed to a cart that contained PPE located inside his bedroom door) and then explained that was after they had administered his morning IV, and that no gown was used for that. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/29/2026 at ~(approximately)08:40 AM, During an interview with NP A she was asked if residents with indwelling lines required precautions, she said that was up to the facilities policy and added, But, yes, it is an open line and said that EBP was indicated for R15. On 01/29/2026 at Noon, During an Interview with ICP Nurse G was asked if R15 met criteria to be in precautions, she said yes, that he had a PICC line for IV antibiotics and a wound on his right foot. She said R15 should have been on EBP since admission stated, I swear there was a sign posted when I did an audit on Monday (01/26/2026) and said, when I put them up, they disappear. A record review of R15's Orders revealed:Start Date: 12/31/2025 . End date: 02/24/2026: Contact precautions every shift related to Cellulitis A Record review of R15's care plan revealed: Date: 12/24/2025 Focus: (R15) requires enhanced barrier precautions related to impaired skin integrity and IV access. Interventions: Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray; Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis); Review with visitors and family members how to follow the recommended precautions when visiting if prolonged physical contact is anticipated. Resident #7 (R7): According to a review of R7's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to anoxic brain damage, chronic diastolic heart failure, diabetes mellitis 2 (DM), Tracheostomy (tube to facilitate breathing), Gastrostomy (tube for nutrition, hydration and medication administration). R7's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) score of 00/15 that indicated the resident was severely cognitively impaired. On 01/29/2026 at 10:21 AM, During tracheostomy care for R7 Nurse D was observed, Nurse D set up the bedside table with a bath towel barrier with supplies placed on top, no sterile barrier was used to drop sterile gauze and sponges onto. Nurse D then opened the sterile suction pack and placed the sterile gloves on, there was no sterile water available on the clean field, observed that Nurse D reached over the field to a plastic supply cart and grabbed a bottle of sterile water and placed it onto the field where the sterile cannula and suction equipment were open. After Nurse D hooked up the suction tube she reached a crossed the field to the suction machine both to turn it on and off and Nurse D exclaimed Oh shoot, I know I am not supposed to reach over my table. On 01/29/2026 at noon, during an interview with ICP nurse G she was queried if Trach care and suctioning was clean or sterile technique and she replied it is sterile technique; she was asked if it is appropriate to reach a crossed the sterile field and place nonsterile items within the field and she responded, No it is not. A record review of R7's orders revealed: Trach care every shift and as needed. Assess stoma site and under trach collar. Change trach ties with showers and as needed. And Suction tracheostomy as needed.Use enhanced barriers while performing high-contact activity with the resident. A record review of R7's care plan revealed: Focus: (R7) requires enhanced barrier precautions related to Tracheostomy and feeding tube.Interventions: Use gown and gloves when providing direct care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Face protection may be needed if performing activity with risk of splash or spray; Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis); Review with visitors and family members how to follow the recommended precautions when visiting if prolonged physical contact is anticipated. According to a record review of facilities policy titled Tracheostomy care and suctioning procedure revealed:Policy: Tracheal suctioning is performed by a licensed nurse to clean the throat and upper respiratory tract of secretions that may block the airway. Guideline: .7. Using sterile technique, open the suction catheter kit and put on the sterile gloves. Consider the glove on your dominant hand sterile, and the non-dominant hand clean. 8. Using non-dominant (clean) hand, pour the normal saline solution into the disposable sterile solution container. 9. Remove the suction catheter from its wrapper with dominant (sterile) hand, coiling it to keep it from touching a non-sterile object.10. Attach the suction catheter to the tubing using non-dominant (clean) hand and turn on suction machine. According to a record review of facilities policy titled Enhanced barrier precautions revealed:Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Definitions: Enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during highcontact resident care activities.Guidelines: . Initiation of Enhanced Barrier Precautions: 2b. Even if the resident is not known to be infected or colonized with a MDRO, an order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers. Note: Wounds generally include chronic wounds, not shorter-lasting wounds such as skin breaks or skin tears covered with an adhesive bandage (e.g. Band-Aid) or similar dressing. ii. Indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy / ventilator tubes). Note: A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purposes of EBP. iii. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply. And 3. Implementation of Enhanced Barrier Precautions may include but is not limited toa. Make gowns and gloves readily available near or outside of the resident's room. Note: Face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation Tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not be needed to be donned prior to entering the resident's room.4. High-contact resident care activities to consider include: . g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: for chronic wounds described above.7. Examples of targeted and epidemiologically important MDROs include but are not limited to: . f. Methicillin-resistant Staphylococcus aureus (MRSA).8. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility, or at the determination by the clinical team of the decreased risk of transmission. A review of the CDC Guidance to Nursing homes on EBP reveals: Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Standard Precautions still apply while using (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. Enhanced Barrier Precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized. Record review of the facility 'Infection Prevention and Control Program' policy dated 12/27/2023 revealed that the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines . A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections . Record review of facility 'Infection Surveillance' policy dated 10/26/2023 revealed a system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections, monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. in an interview and record review on 01/28/2026 at 1:51 PM during the infection control task with Licensed Practical Nurse (LPN)/Infection Control Preventionist (ICP) G (2 months) in training, and Registered Nurse (RN)/Regional Director of clinicals/Infection Control Preventionist (ICP) J. The state surveyor inquired about Enhanced Barrier Precautions (EBP)- staff are given education on orientation and annually, as needed. And utilized where posted, signs on resident room entrances identify what staff are to wear (Personal Protective Equipment) when in close contact with resident. Close contact, touch, moving, emptying catheter bags, personal care all need EBP for that resident. Resident #124: Record review of Resident #124's progress notes dated 1/19/2026 at 4:06 PM noted the resident returned from hospital and assessment was completed. Record review of Resident #124 vital signs dated 1/19/2026 at 3:32PM noted forehead temperature of 101.3. Record review of Resident #124's Medication Administration Record (MAR) noted that on 1/20/2026 antibiotic Meropenem intravenous 1 gram every 8 hours for sepsis. Record review of Resident #124's readmission Minimum Data Set (MDS) dated [DATE] noted a female with Brief Interview of Mental status (BIMs) score of 13 out of 15, cognitively intact. Active medical diagnoses included: hypertension, Gastroesophageal reflux disease, renal insufficiency, diabetes, seizures, malnutrition, anxiety, depression, schizophrenia, chronic obstructive pulmonary disease and sepsis (life threatening infection). Section N: Medications identified antibiotic, antiplatelet, and antipsychotic medications. Observation and interview on 01/27/2026 at 9:49 AM of Resident #124 was lying in bed, she stated that she has a belly tube and the IV in her right arm. Resident #124 showed the state surveyor her right upper arm Peripheral Inserted Central Catheter (PICC) and abdominal gastrointestinal tube site. Observation of gastro tube had no split sponge gauze dressing noted to the site. Resident #124 was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	infrequently used fixtures weekly. On 01/27/2026 at approximately 1:00pm-1:30pm observed a utility sink with an attached hose and a chemical feed downstream of an atmospheric vacuum breaker. During this observation, Housekeeping Manager L was asked if she was familiar with a wasting tee and she said she was familiar with them and she put in an order for one already. According to the 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve). On 01/27/2026 at approximately 2:45-2:50pm observed water flooding into office area in the 700 hallways in the Coordination Center. This surveyor was informed by the Maintenance Director M that there was a burst pipe. On 01/27/2026 at 3:00pm observed water streaming in from the light fixture above the hand sink in room [ROOM NUMBER]. On 01/28/2026 at 9:15 am when interviewed Maintenance Director M on how long the drinking fountains in the facility have been shut off, he stated they've been shut off since Covid. On 01/28/2026 at 9:20am in the supply room located in the main kitchen, the unused filter was removed from the water line, and the remaining water line was leaking. On 01/28/2026 at approximately 9:25am-9:40am hot water was temped at 103 degrees F using Thermapen from the bathroom hand sink in room [ROOM NUMBER]. During this observation, Maintenance Director M was asked what range the hot water should be kept at and he stated it should be between 105-120 degrees F On 01/28/2026 at approximately 9:25am-9:40am observed discolored water at hand sink in room [ROOM NUMBER]. Maintenance Director M stated the discolored water was a result of the water being shut off the day prior due to a burst pipe and staff was told to run some faucets after the water came back on. The hot water was temped at 106 degrees F using Thermapen at the same hand sink. On 01/28/2026 at approximately 9:25am-9:40am the hot water was temped at 103 degrees F using Thermapen at the bathroom sink in room [ROOM NUMBER]. On 01/28/2026 at approximately 9:35am the hot water was temped at 105 degrees F using Thermapen at the bathroom sink in room [ROOM NUMBER]. On 01/28/2026 at 9:45am the hot water was temped at 91 degrees F using Thermapen at the bathroom sink in room [ROOM NUMBER]. On 01/28/2026 at approximately 11:35 AM when interviewed the Administrator on the range for hot water temperatures, and he answered they aim for 105-120 degrees F, as it states on the facility's hot water temperature logs. When asked about the conflicting hot water temperature range in the water management binder where it states hot water temperatures that fall below 110 degrees F needs corrective action, he stated that it's referring to the holding tank temperatures. (continued on next page)

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Medilodge of Montrose Inc	9317 West Vienna Road Montrose, MI 48457

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility's hot water log temperatures show 105 degrees F in room [ROOM NUMBER], 105.1 degrees F in room [ROOM NUMBER], and 105.3 degrees F in room [ROOM NUMBER] on 1/23/26. In addition, hot water temperatures are 105.1 degrees F in room [ROOM NUMBER], 105.5 degrees F in room [ROOM NUMBER], and 105.3 degrees F in room [ROOM NUMBER] on 1/19/26. According to the facility's water management plan on operation, maintenance, and control limits, Hot water temperatures that fall below 110 degrees F require corrective action. According to the facility's hot water temperature logs, the hot water temperature range is listed as 105 degrees -120 degrees for Michigan.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility to ensure that monthly infection control antibiotic stewardship data collections were completed, 1) antifungal monitoring and stop dates, 2) Resident #6's prophylactic antibiotic line listing, 3) Resident #15's Vancomycin scheduling, dosing and therapeutic level monitoring, and 4) Resident #124 to receive antibiotic with no temperature monitoring, resulting in the high likelihood of increased antibiotic usage and resident infection rates with hospitalizations. Findings include: Resident #15 (R15): According to a review of R15's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to cellulitis (bacterial infection) of the right lower limb, abscess of right lower limb, Osteomyelitis (infection in the bone), Methicillin Resistant Staphylococcus Aureus (MRSA) infection (bacteria that is resistant to many antibiotics, including methicillin) and has a peripherally inserted central catheter (PICC) and receiving IV Vancomycin (an antimicrobial medication used to treat resistant bacteria) with 6 weeks remaining on IV therapy. R15's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) score of 15/15 that indicated the resident was cognitively intact. Additional medical diagnoses included: Chronic Obstructive Pulmonary Disease (COPD/progressive lung disease) Muscular dystrophy, Hypokalemia (low potassium), and weakness. On 01/28/2026 at 11:34AM, During an interview with Nurse I she was asked about R15's Vancomycin IV schedule for observation, Nurse I said it is a twice a day medication and given once in am and once in the pm. Nurse I said that she had given the morning dose at 6:16AM. When asked what the scheduled times were for the Vancomycin, she stated it is scheduled at liberal time. Nurse I was asked what at liberal time meant she replied that at liberal time in the AM was from 7-10 AM and the PM was from 8-11PM. Nurse I declared I am allowed to go 1 hour before scheduled time or 1 hour after schedule time to administer medications. Nurse I said R15's Vancomycin is BID (2 times a day), every 12 hours. Nurse I was queried about the scheduled Vancomycin to be given at a 12 hour interval with the at liberal schedule, she said oh I can see how that is a problem, maybe it should be a scheduled time. Nurse I stated, I am calling the NP for my piece of mind on it. According to a record review of R15's orders revealed the following: Start date: 12/24/2025 scheduled: ordlib_HS (at liberal) time ranges: 0700-1000 and 2000-2300. Medication: Vancomycin HCl Intravenous Solution 1000MG/200ML (Vancomycin HCl) Use 1 gram intravenously two times a day for osteomyelitis for 6 weeks. Pharmacy to adjust dosage as needed . Duration 6 weeks end date: 02/04/2026. According to a review of Food and Drug administration (FDA) Vancomycin prescribing information/FDA label related that, the usual daily dose IV dosage of Vancomycin injection is 2 grams divided either as 500mg every 6 hours or 1 gram every 12 hours. 01/28/2026 at ~12:40PM, Nurse I knocked on the door of office and advised SA that she had talked to NP A about the at liberal times for the Vancomycin. Nurse I said that 'NP A had advised her to adjust the order for R15's Vancomycin to be scheduled Q(every)12 hours for consistency of administration' and that it was no longer scheduled for the at liberal time. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to a record review of R15's updated orders revealed: Revision date 01/28/2026 Start date: 12/24/2025 scheduled: two times a day times 0700 and 1900 . Medication: Vancomycin HCl Intravenous Solution 1000MG/200ML (Vancomycin HCl) Use 1 gram intravenously two times a day for osteomyelitis for 6 weeks. Pharmacy to adjust dosage as needed . end date: 03/11/2026. According to a record review of R15's lab results Vancomycin Trough levels were absent in the resident's chart. On 01/29/2026 at ~(approximately)08:40 AM, During an interview with NP A she was asked about how Vancomycin was dosed and she said R15's Vancomycin was dosed by the pharmacy. She was asked how Vancomycin for R15 was ordered and she said it was ordered Vancomycin 1000mg to be given BID. NP A was asked how Vancomycin BID should be scheduled, she said Q12 hours. NP A was asked if it was standard to schedule and administer Vancomycin as at liberal times and clarified the AM dose was scheduled as 7-10 AM with an hour administration window before or after, and the PM dose was scheduled as 2000-2300 (8-11PM) with an additional hour administration window before or after, NP A stated No, it is not. NP A said she talked to Nurse I and clarified the order after it was brought to her attention on (01/28/2026). During the continued interview with NP A was asked about monitoring the Vancomycin, she said it is per pharmacy to dose. NP A was asked about R15's last peak and trough levels, after she looked in R15's chart she said, there are no results for me to review. NP A was asked how long R15 had been on Vancomycin, she said since he was admitted , clarified as 12/24/2025. After NP A reviewed R15's orders, she confirmed that R15 had not had any peak and trough labs ordered or drawn while at the facility. When NP A was asked how the therapeutic level was monitored she deferred to the orders that stated, Pharmacy to dose. On 01/29/2026 at Noon, During an Interview with ICP Nurse G she was asked R15's admission date, she confirmed 12/24/2025. ICP Nurse G confirmed that R15 was admitted to facility on IV Vancomycin 1000mg BID. ICP Nurse G was asked about R15 peak and trough lab results, she said the infectious disease (ID) doctor ordered the medication and order stated, Pharmacy to dose. ICP Nurse G confirmed that R15 had been at the facility for greater than 30 days and that no lab for peak and trough had been done. (peak and trough testing is used to monitor therapeutic drug levels-minimizing adverse effects and optimizing therapeutic effects of medication) ICP Nurse G said they did not get a note back from the pharmacy when the order was sent to them. ICP Nurse G was asked if they received a note for dosing whether labs are needed or not, she said yes, we do, if they are not requested then it would specify you do not need to monitor or something to that effect. ICP Nurse G was queried if there was a note from the pharmacy that stated there was no need to monitor for R15, she said no, I do not have one. ICP Nurse G was asked if she had followed up with the pharmacy about peak and trough labs for R15, she said I called the pharmacy yesterday (1/28/2026) about a lab request, confirmed with ICP Nurse G call was after being interview with SA for infection control program. ICP Nurse G said she asked them (the pharmacy) what to do for R15 because no lab had been requested for peak and trough. ICP Nurse G reported the pharmacy response was 'Oh, yeah we should probably get those' and said that they gave her a verbal order to place an order for peak and trough for (01/29/2026). ICP Nurse G advised SA that once the labs were drawn it would take a day to receive results. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ICP Nurse G was queried about Vancomycin 1000mg BID order and how it would be scheduled, she said it would be Q 12 hours and further said it should be scheduled at a set time for proper spacing of doses. According to a record review of R15's orders revealed the following: Date 01/29/2026: Enter Labs into [NAME] for tomorrow: Weekly Vancomycin trough draw 30 mins to 1 hr before dose, BUN, and Creatinine. According to the Infectious Disease Society of America (IDSA) Vancomycin guidelines 2020 Update, The guidelines recommend an AUC/MIC (Area Under Curve/Minimum Inhibitory Concentration) ratio (parameter to assess effectiveness of an antibiotic) of 400–600 mg*hour/L to achieve clinical efficacy and ensure safety for patients being treated for serious methicillin-resistant Staphylococcus aureus infections and according to the IDSA clinical practice guideline recommendation achieving a trough (parameter to assess effectiveness of an antibiotic) concentration of 15-20 mg/L (milligram per liter) for complicated infections. These guidelines emphasize the importance of consistent and timely administration of vancomycin to maintain therapeutic exposure and endorsed Interruptions in therapy can lead to suboptimal drug exposure and potential therapeutic failure. On 02/02/2026 at 8:52AM, During an interview with NP A she was about R15's Peak and Trough labs that were ordered on 01/29/2026 and she said they were drawn, but I have no results to review in the chart and further said she was unaware of the results verbally. NP A was queried about the Vancomycin dose that was held for the lab draw and then restarted with no results reviewed, she said I did not tell them to do that. On 02/02/2026 at 8:59AM, During an interview with ICP Nurse G was queried about R15 peak and trough lab results, she said she ordered the labs to be drawn in (name of lab contractor) system for the drawn to be done for Friday (01/29/2026) morning. ICP Nurse G was asked if R15's labs were drawn. ICP Nurse G said that on Friday (01/29/2026) afternoon she called the (contract company representative name) because she was unable to find the order in the system and R15's labs had not been drawn, ICP Nurse G further exclaimed that she had no idea what happened to the order. ICP Nurse G said she then put in a STAT (rush) order for the labs to be drawn in house and taken to (hospital lab). She said that Nurse C had drawn R15's blood and that staff member E took them to the (hospital lab) on her way home (01/29/2026). ICP Nurse G reported that there was no receipt of drop off from (hospital lab) for the specimen and that (hospital lab) said 'they have no record of it'. R15 had already had his Vancomycin on Saturday. ICP Nurse G said she had requested a new order to hold a dose to draw the lab the next morning on 02/01/2026. ICP Nurse G said a dose of R15's Vancomycin was held and blood was redrawn on Sunday (02/01/2026), and the UM N dropped them off at the hospital lab. ICP Nurse G was asked about results from the 02/01/2026 specimen and she said we do not have them. ICP Nurse G said the DON (who was not available due to illness) had access to the (hospital lab) site checked for results and it said the specimen was rejected. ICP Nurse G stated we are going to draw the labs today (02/02/2026) STAT. According to a record review of R15's orders revealed the following: Date: 01/31/2026: Extend ABX (antibiotic) Vancomycin 1 day due to missed does (dose) waiting for labs to be drawn Revision date: 01/31/2026: Start date: 12/24/2025 scheduled: two times a day times 0700 and 1900. Medication: Vancomycin HCl Intravenous Solution 1000MG/200ML (Vancomycin HCl) Use 1 gram (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Antibiotics use protocols: i.) Nursing staff shall evaluate residents who are suspected of having infection. Monitoring antibiotic use: i) Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made. (vi) Antibiotic use shall be measured by (monthly prevalence, antibiotic starts, and/or antibiotic days of therapy). (vii) At least outcome measures associated with antibiotic use will be tracked as part of the QAPI program monthly, as prioritized Record review of facility antibiotic line listing monthly monitoring from January 2025 through January 2026 was reviewed. Interview and record review on 01/28/2026 at 1:58 PM with Licensed Practical Nurse (LPN)/Infection Control Preventionist (ICP) G and Registered Nurse (RN)/Regional Director of clinicals/Infection Control Preventionist (ICP) J stated that there was no line listing prior to October 2025 in the binder. Record review of a large white three ring binder noted: January 2025 no monthly resident documentation found related to infections/antibiotic used within the month, no mapping, a computerized line listing with no organisms listed with for the treatment with antibiotics, no monthly infection control analysis and summary. There was multiple 'Validation checklists' provided. February 2025 no line listing, no mapping surveillance, no analysis or monthly summary provided. March 2025 no line listing, no mapping surveillance, no analysis or monthly summary provided. April 2025 binder tab held a computerized mapping and 'Validation Checklists'. No monthly resident documentation found related to infections/antibiotic used within the month, no line listing with no organisms listed, no monthly infection control analysis and summary. May 2025 no line listing, no mapping surveillance, no analysis or monthly summary provided. June 2025 no line listing, no mapping surveillance, no analysis or monthly summary provided. Validation checklists were found under the June 2025 tab. Record review of Resident #6 was placed on prophylactic antibiotic Cephalexin oral capsule 250mg one time daily at bedtime indefinitely dated 6/15/2025 and there was no risk vs benefits documentation for the use of the antibiotic. July 2025 no line listing, no mapping surveillance, no analysis or monthly summary provided. August 2025 no line listing, no mapping surveillance, no analysis or monthly summary provided. September 2025 Record review of the line listing provided noted 9 residents placed on Nystatin anti-fungal medication with no stop dates and no body site/location of use to monitor. There were no infectious organisms identified on the line listing for treatments with antibiotics. There was no analysis or monthly summary provided or trends for the spread of rash. Record review of Resident #6 was placed on prophylactic antibiotic Cephalexin oral capsule 250mg one time daily at bedtime indefinitely dated 6/15/2025 was not on the line listing. October 2025 Record review of the line listing provided noted residents placed on Nystatin anti-fungal (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medication with no stop dates and no body site/location of use to monitor. There were no infectious organisms identified on the line listing for treatments with antibiotics. There was no analysis or monthly summary provided or trends for the spread of rash. Record review of Resident #6 was placed on prophylactic antibiotic Cephalexin oral capsule 250mg one time daily at bedtime indefinitely dated 6/15/2025 was not on the line listing. November 2025 Record review of the line listing provided noted residents placed on antibiotic medications without an organism identified on the line listing for treatments with antibiotics. There was no analysis or monthly summary provided or trends for the spread of infection. No facility November 2025 mapping/tracking provided to surveyor. There was staff training on 'Enhanced Barrier Precautions' policy with signature sheets with no dates when education was given. Record review of Resident #6 was placed on prophylactic antibiotic Cephalexin oral capsule 250mg one time daily at bedtime indefinitely dated 6/15/2025 was not on the line listing. December 2025 Record review of the line listing provided noted Resident #15 placed on Vancomycin antibiotic medication from 12/24/2025 through 2/4/2026. The State surveyor inquired to see Peak & Trough (P&T) therapeutic level monitoring of the antibiotic and was told that there were no Peak & Troughs performed. Registered Nurse (RN) J had no answer for monitoring the antibiotic therapeutic levels and was not aware that there were none done. There was no analysis or monthly summary provided. Record review of Resident #15's physician orders revealed Vancomycin 1000mg intravenously twice daily. Record review of Resident #6 was placed on prophylactic antibiotic Cephalexin oral capsule 250mg one time daily at bedtime indefinitely dated 6/15/2025 was not on the line listing. January 2026 line listing generated on 1/28/2026 did not have infectious organisms noted or Resident #6 prophylactic antibiotic Cephalexin oral capsule 250mg one time daily at bedtime indefinitely dated 6/15/2025 was not on the line listing. Resident #15 (R15): In an interview and record review on 01/29/2026 at 8:20 AM with Nurse Practitioner (NP) 'A' on Resident #15's Vancomycin antibiotic 1000mg twice daily intravenous started on 12/24/2025 through 2/4/2026. NP 'A stated that Vancomycin Peak & Trough is done to determine how much vancomycin antibiotic a resident should be receiving. The order is for pharmacy to determine dosing. There are no peak & troughs for over 30 days, record review of the labs/orders review revealed no Peak & Troughs found. Pharmacy services need to call them for answer. Vancomycin is execrated through the kidneys. We do weekly renal labs. Nurse Practitioner A was asked if there was a risk vs benefits for the prophylactic use of antibiotic for Resident #6, the NP A stated that no she did not do one because that should be hospices call. In an interview on 02/02/2026 at 9:19 AM with Registered Nurse (RN)/Regional Clinical Director J, was asked about the Vancomycin peak & trough blood work/lab that was to be drawn on Friday 1/30/26. RN J stated that it was missing and a stat draw will be done this morning, because the hospital lab rejected the sample. In an interview and record review on 02/02/2026 at 9:25 AM Licensed Practical Nurse (LPN)/Infection Preventionist G (LPN/ICP) stated that Resident #15's Vancomycin 1000mg IV and that there was no Peak & trough (P&T) for therapeutic levels for the last 37 days- started 12/24/25 and is still getting the medication. On Wednesday 1/28/26 during the IC task, surveyor asked for the (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	P&T results, and we identified that there were none. On Thursday 1/29/26 we ordered a P&T for Friday 1/30/26 in the morning, No order in the computer lab system. Friday morning results I went to look in the afternoon and couldn't find the results or order in the [NAME] system. I emailed the [NAME] lab representative, and I have not heard back from him yet. On Friday 1/30/25 we drew blood, a nurse from 300 hall drew the blood and staff member Discharge Planner E was to drop it off on her way home to [NAME]. On Saturday 1/31/2026, I text the nurse management a group text asking if anyone got the results, no one knew where the lab went. Resident #15 missed only one dose on Friday morning and then we got no results, so we drew blood again on Sunday 2/1/26 morning and Licensed Practical Nurse (LPN/UM) the unit manager dropped off the sample at the hospital. I checked labs Monday morning 2/2/26, and it was rejected because there is no reason. In an interview on 2/2/2026 at 9:41AM with Discharge Planner staff E stated that on Friday she left at 7:30-8:00PM and was to take the blood sample to the hospital but did not take the blood because she forgot about it. On Saturday he already had his dose so they couldn't draw the blood, and they were to draw it on Sunday and drop it off. In an interview and record review on 02/02/2026 at 9:48 AM with Nurse Practitioner (NP) A stated that she was notified by state surveyors on 1/29/26 of no peak & trough, so she told facility to contact pharmacy for Vancomycin directions to dose by pharmacy. pharmacy gets the results. On Friday the pharmacy said to hold the medication just to get labs, hold temporary to get labs. Resident #15 only missed one dose Friday morning; there is no trough there are no results for me to review. The resident went on Monday 2/2/26 in the morning to Infectious disease doctor and to Discontinue the PICC line, therapeutic levels not drawn. Vancomycin antibiotic, the monitoring would be up to pharmacy's discretion. Now we are going to pull the PICC line and stop the antibiotic with no therapeutic levels monitored or checked.

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	235600	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 West Vienna Road Montrose, MI 48457

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure that there were adequate staff and/or that staff were utilized appropriately to sufficiently meet the needs of facility residents resulting in increased call light response times, unmet care needs, lack of resident assessment and monitoring.Findings Include:During Resident Council on 1/28/2026, the eight attendees reported the following regarding staffing at the facility:There are not enough staff to meet their needs, and the facility terminates the good staff or forces them out.There is currently a mass exodus of nurses due to how the facility is run and the nurses left do not having enough time to ensure all their needs are met.At times they can have up to three different nurses providing care to them during one shift.Average call light wait time is about 30 minutes and that is across all shifts. On 1/29/2026 at 1:10 PM, an interview was conducted with Staffing Coordinator BB regarding facility staffing. Coordinator BB shared over the last three months approximately ten staff (nurses and aides) have resigned from their positions. When asked if they provided reasoning regarding their resignation, it was reported some would not provide a reason and others stated upper management concerns. Within the last month one nurse and two aides have put in their notice of resignation. Coordinator BB was asked how many openings they currently have, she stated the following:1 nurse on day shift4 nurses on night shift1 aide on day shift The short-term unit is split into four halls- 100, 200 and 300 halls each have an assigned nurse. The nurse for 100 and 200 halls split the 400 hall. It can be noted there are separate halls that are not connected to one another. There is one CNA assigned to each hall to care for the residents and if a resident is a two-person assist they will radio for assistance. On the long-term care unit there is one nurse assigned to 500 and 700 halls and the two nurses split 600 Hall. On 1/29/26 at 4:00 PM, the DON (Director of Nursing) was queried why a resident was unable to remain on the restorative program. The DON stated they do not have staffing to maintain the restorative program. Review was conducted of Resident Council Minutes from January 2025 to present and the resident expressed concern with staffing on multiple occasions.Resident Council Notes:2/11/2025: .Night & day shift cna staff on cell phones.nursing staffing has been challenging/short. 3/11/2025 .staffing has been challenging.4/8/2025: .Staffing has been challenging.Not seeing MOD (manger on duty) on the weekends.6/17/2025: .Call lights are not answered timely on nights and weekend.8/12/2025: .CNA call ins nights and weekends.9/24/25 .Concerned about low employee morale.long wait time for call lights. 10/28/28 (10/28/25) .Some nurses going too fast when providing med.11/18/25 .Some nurses going too fast when providing med.12/22/25 .Some nurses going too fast when providing med.delivery of medications at times late.Concern regarding nurses sharing/splitting 400 Hall. The facility was asked to provide the number of two person assist (this includes mechanical lifts) within the facility. The facility has the following:Short term unit: 12 two-person assistsLong term unit: 15 two- person assist During confidential interviews with facility staff the following was reported regarding staffing concerns:The CNA (certified nursing assistants) rarely take their breaks due to the acuity of the unit. The acuity has been increased for approximately 6-8 months, but the staffing has not increased to meet the needs. More than ten residents require assistance with feeding and the pulls the aides away from direct care during meal times. They are unable to take their time resident care as they have to rush off to the next thing. Many staff are leaving as it has become overwhelming to manage in the current environment. There are nursing tasks that are missed due to the lack of staffing.The mandation is becoming overly common and many times their evening managers are working the carts due to lack of staffing. There is poor staff morale due to concerns over capabilities of leadership. On their units they have multiple PEG (percutaneous endoscopic gastrostomy) tubes, bolus feeds, IV (intravenous) antibiotics, hospice residents, postoperative patients and residents with surgical incisions. During the four-day annual/abbreviated survey the facility was deficient in the following resident care areas that (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are directly related to staffing:Daily grooming provided to residentsAssessment and monitoring of newly identified skin conditions, tube feeding site and weight lossLack of resident related documentation and coordinator of care

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% when three medication errors were observed for three residents (Resident #56, Resident. #59, and Resident #111) for a total of 26 observations, resulting in a medication error rate of 11.5%. This deficient practice resulted in the potential for adverse medication effects and decreased medication efficacy related to medications administered late and the lack of implementation of standards of practice for medication administration. Findings include:Resident #56: A medication pass observation was completed on 1/28/26 at 2:57 PM for Resident #56 with Registered Nurse (RN) AA. RN AA prepared Mirapex (medication used to treat symptoms of Parkinson's disease including tremors and stiffness as well as Restless Legs Syndrome) 1 milligram (mg) tablet for administration to the Resident. The Medication Administration Record (MAR) specified the medication was supposed to be administered at 1:00 PM. RN AA was asked why they were not administering the medication until now when it was due at 1:00 PM and responded that they were unable to get to the Resident's room to administer the medication due to the floor being remodeled/replaced in the hallway. When queried why Resident #56 was in their room if staff were unable to get to them due to the current remodel construction occurring in the facility, RN AA did not provide an explanation.Resident #111:A medication observation for Resident #111 was completed on 1/29/26 7:11 AM with RN Z. RN Z prepared medications for the Resident at the medication cart by removing the medications from the blister packs and placing them in a medication cup including one metoprolol succinate (medication used to treat high blood pressure and heart failure) 25 milligram (mg) Extended Release (ER) tablet. RN Z proceeded to crush all the medications in the cup. Prior to administration, RN Z was stopped prior to administration and queried regarding crushing extended-release medications. RN Z stated, That is what we do. I will have to call the Doctor I guess. With further inquiry, RN Z stated, That is what we always do. RN Z proceeded to administer the crushed medications, including the crushed metoprolol succinate 25 mg ER tablet.Resident #59:On 1/29/26 at 7:28 AM, a medication observation for Resident #59 was completed with RN Z. After preparing medications at the medication cart outside of the room, including oral medications and Breo Ellipta 100/25 mcg (microgram)/inh (inhalation) inhaler (once a day inhaler to improve breathing), RN Z entered Resident #59's room. The first medication RN Z administered to Resident #59 was the Breo Ellipta inhaler. RN Z prepare the inhaler dose and handed the inhaler to the Resident. Resident #59 put the inhaler in their mouth and took two rapid breaths. RN Z did not educate the Resident on proper inhaler use. After using the inhaler, Resident #59 did not rinse their mouth with water and spit.An interview was completed with RN Z after exiting Resident #59's room on 1/29/26 at 7:40 AM. RN Z was asked about Resident #59 taking two rapid breaths when taking the medication and indicated the Resident does that but can only receive one dose due to the inhaler. When queried regarding rinsing with water and spitting after administration of a Breo Ellipta inhaler, RN Z stated, (Resident #59) usually doesn't. No further explanation was provided.An interview was completed with the Director of Nursing (DON) on 1/29/26 at 9:08 AM. When queried if extended-release medications should be crushed, the DON responded they should not. The DON was then informed of RN Z crushing and administering extended-release metoprolol succinate to Resident #111 even after being stopped by Surveyor. When queried regarding their thoughts, the DON stated, The nurse chose not to follow policy/procedure and they would provide education. The DON was then asked if residents should rinse their mouth after using a Breo Ellipta inhaler and verbalized they should. The DON was informed of Resident #59 not rinsing and spitting during medication pass observation and did not provide further explanation. When queried regarding Resident #56 receiving their Mirapex late and RN AA stating they were unable to get to the Resident in their room due to the remodel and flooring installation in the building, the DON indicated that was not an acceptable reason to administer medication late. When asked why Resident #56 was in their room if staff were unable to get to them, the DON responded that staff should be able to reach (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents at all times. Review of facility policy/procedure entitled, Medication Administration (Reviewed/Revised: 1/17/23) revealed, Medications are administered by licensed nurses. as ordered by the physician and in accordance with professional standards of practice. 11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time of administration. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. 14. Administer medication as ordered in accordance with manufacturer specifications. c. Crush medications as ordered. Do not crush medications with ?do not crush' instruction.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to operationalize policies and procedures for medication storage in one of one medication rooms and four of five medication carts, resulting in open, undated, expired, and inappropriately stored medications. Findings include:On [DATE] at 7:09 AM, an open fabric open zipper bag with visible personal items including hand lotion, hand sanitizer, and pens along with a teal-colored Yeti cup were observed sitting on the top of the 700 Hall Medication Cart. There were no staff present at the cart and/or in the hallway. RN Z was observed approaching the medication cart. When asked if the items on top of the cart were theirs, RN Z confirmed they were. RN Z was asked if they are supposed to have personal beverages/cups on top of the medication cart, RN Z did not provide a verbal response but proceeded to remove the bag and cup from the cart. A tour of the 600 Hall Medication Cart was completed on [DATE] at 8:22 AM with Licensed Practical Nurse (LPN) T. A 2.5 milliliter (mL) unopened bottle of Rhopressa 0.02% ophthalmic solution (prescription eye drop used to lower pressure in the eye) for Resident #105 was present in the medication cart. The instructions on the bottle specified the medication should be stored in the refrigerator until opened. A tour of the facility medication storage room was completed on [DATE] at 8:46 AM with LPN T. Two 12 count boxes of Hemorrhoidal Suppositories with an expiration date of [DATE] were present in the medication room. On [DATE] at 2:31 PM, a tour of the 500 Hall Medication Cart was completed with LPN T. The medication cart contained an unopened vial of Lantus 100 units/mL insulin for Resident #8. The insulin was labeled to keep refrigerated until opened. Per the medication label, it was delivered to the facility on [DATE]. A tour of the 300 Hall Medication Cart was completed on [DATE] at 10:24 AM with Registered Nurse (RN) C. The following was present in the cart: - Latanoprost 0.005% ophthalmic solution (prescription eye drop used to lower pressure in the eye) for Resident #72. The medication package was a dark colored bag was labeled Package Protect from light. The medication was on top of and not stored inside the dark colored bag.- Brimonidine 0.2% ophthalmic solution (prescription eye drop used to lower pressure in the eye) for Resident #72. The medication was opened and undated.- A vial of Lantus (insulin) 100 units/mL for Resident #128. The insulin was opened and undated.- A vial of Lispro (insulin) 100units/mL for Resident #128. The insulin was opened and undated.- A 30-count box of Duoneb (nebulizer inhalation solution used to improve airflow) 0.5 mg/ 3 mg three mL vials for Resident #95. The medication was dated as opened [DATE]. The instructions on the medication box specified, Vials should be used within 2 weeks of opening.- A 30-count box of Duoneb (nebulizer inhalation solution used to improve airflow) 0.5 mg/ 3 mg three mL vials for Resident #73. The medication was open and undated.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to operationalize policies and procedures to ensure that residents were treated in a dignified and respectful manner for two residents (Resident #32 and Resident #69) of four residents reviewed, resulting in staff not knocking prior to entering residents' rooms and a lack of timely care resulting in incontinence, and resident's verbalizations of dissatisfaction with care. Findings include:Resident #32: On 1/28/26 at 9:24 AM, Resident #32 was observed sitting in a wheelchair in their room. An interview was completed at this time. When queried regarding the food and care they receive in the facility, Resident #32 replied, The food is slop and the facility is short staffed. With further inquiry, Resident #32 stated, It makes you feel mean, you are waiting all the time for something in here. Resident #32 was asked how they are treated by staff and stated, I feel like this is the ignored room. When asked to explain, Resident #32 verbalized they have to wait for hours when they want to be transferred. When asked why they have to wait so long, Resident #32 responded that they require the Sit to stand (mechanical lift) and have to use the toilet in the shower because it wont fit in my room. With further inquiry, Resident #32 revealed they have a urostomy (surgically created opening in the abdomen to the bladder for the drainage of urine) and sometimes know when they need to have a bowel movement. Resident #32 stated, I put on my light when I think I have to go, but it takes them (staff) an hour or more (to answer light). Resident #32 continued, The one day I was sitting outside (room), not five feet from the toilet shitting myself. That is so embarrassing for an old lady. When queried if staff respect their privacy, Resident #32 replied, I have no privacy. They (staff) just walk in and not knock. At 9:43 AM on 1/28/26, while speaking with Resident #32 in their room, Certified Nursing Assistant (CNA) CC was observed entering Resident #32's room without knocking. Record review revealed Resident #32 was most recently readmitted to the facility on [DATE] with diagnoses which included diabetes mellitus, multiple sclerosis, depression, and pain. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, was dependent upon staff for transferring, and frequently incontinent of bowels. Resident #69:On 1/27/26 at 3:34 PM, Resident #69 was observed sitting in an electric wheelchair in their room and an interview was completed. When queried how they are treated by facility staff, Resident #69 replied, It takes them forever to get to my light. When queried if the staff treat them with respect, Resident stated, Sometimes. When asked what sometimes meant, Resident #69 responded that some staff have an attitude when they come in their room. Resident #69 was asked what they meant by attitude and replied, Just treat me like I'm bothering them. When asked if there were specific staff that made them feel that way, Resident #69 revealed it was mainly night shift staff. When queried what the staff say that make them feel that way, Resident #69 revealed they say, What do you want? with a tone when they put on their call light for assistance. With further inquiry, Resident #69 stated, They are really rough when they are positioning me and indicated the staff are moving fast and not being careful. Resident #69 stated, I have two rods in my back, and the head of my femur is out and indicated the staff need to go slower so it causes them less pain. When asked if they informed the staff about this and asked them to slow down, Resident #69 responded they had but indicated it did not make a difference. Record review revealed Resident #69 was most recently readmitted to the facility on [DATE] with diagnoses which included chronic pain, anxiety, and muscular dystrophy (genetic disorder with progressive weakening and wasting of the muscles). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and dependent upon staff for completion of Activities of Daily Living (ADLs). An interview was completed with the facility Administrator on 1/28/26 at 4:45 PM. When queried if they had been made aware of any resident concerns related to long call light wait times, the Administrator responded they had a couple call light (concern) forms. When asked if it is acceptable to wait an hour (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for someone to answer your call light, the Administrator responded, No. The Administrator was then asked if they had received any concerns regarding related to staff treatment of residents and replied, Had some concern forms about rude staff and indicated the concerns were customer service issues. The Administrator was then informed of Resident statements related to staff not knocking, not providing timely assistance, and how staff speak to them. When asked if that was acceptable, the Administrator responded that it was not. Review of facility policy/procedure entitled, Promoting/Maintaining Resident Dignity (Reviewed/Revised: 10/26/23) revealed, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life. 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 5. When interacting with a resident, pay attention to the resident as an individual. 6. Respond to requests for assistance in a timely manner. 10. Speak respectfully to residents.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that physical restraints were not used for one resident (Resident #69) of one resident reviewed, resulting in the use of a seatbelt restraint without an assessment for its use and an evaluation of its appropriateness. Findings include:Resident #69:On 1/27/26 at 3:34 PM, Resident #69 was observed sitting in their room in an electric motorized wheelchair. A seat belt was in place across the Resident's abdomen. An interview was completed at this time. When queried if they were able to undo their seat belt by themselves, Resident #69 replied, No. With further inquiry, Resident #69 stated, I used to be able to, but I can't anymore. Record review revealed Resident #69 was most recently readmitted to the facility on [DATE] with diagnoses which included chronic pain, anxiety, and muscular dystrophy (genetic disorder with progressive weakening and wasting of the muscles). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and dependent upon staff for completion of Activities of Daily Living (ADL). The MDS specified the Resident did not have any restraints in place. A review of the CMS- 802 form revealed the Resident was not marked for having restraints. Review of Resident #69's care plans in their Electronic Medical Record (EMR) revealed the Resident did not have a care plan and/or intervention in place related to seat belt use. Further review of the EMR revealed the Resident did not have a Health Care Provider (HCP) order for seat belt and/or restraint use and no documentation of assessment for seat belt and/or any restraint use. An interview was conducted with the facility Administrator on 1/28/26 at 5:06 PM. When queried if a seat belt on a wheelchair that a resident is unable to undo/disconnect themselves is considered a restraint, the Administrator verbalized they were unsure and would need to review the facility policy. With further inquiry, the Administrator confirmed a seat belt may be considered a restraint. The Administrator stated, Yes, if you can't undo the belt. When asked why Resident #69 had a seat belt in place on their motorized wheelchair which they were unable to undo, the Administrator did not provide a response. When queried why they did not have an assessment for a restraint completed and why the Resident was not listed as having a restraint on the CMS-802 form, the Administrator stated, I will have to discuss with my team. No further explanation was provided. On 1/29/26 at 12:35 PM, an interview was completed with the Director of Nursing (DON). The DON was asked if the Administrator spoke to them regarding Resident #69's seat belt and responded, Yes and we asked the therapy OT (Occupational Therapy) manager to do an evaluation. When queried if they were saying Resident #69 did not have an assessment completed for use of the seat belt, the DON confirmed they did not. The DON was then asked if a seat belt is considered a restraint if the Resident cannot undo the belt by themselves and stated, Yes. When asked, the DON verbalized the seat belt was a restraint. On 1/29/26 at 1:51 PM, Resident #69 was observed sitting in their motorized wheelchair in their room. At interview was completed at this time. Resident #69 was asked again if they could unhook the seat belt and stated, I can't. The Resident was observed attempting to undo the seatbelt latch but was unable to depress the release button. Resident #69 then stated, I told them (staff) I can't. Resident #69 was asked when they informed staff that they could not undo the seat belt by themselves and responded they were unsure of the exact date but that it had been quite a while. Review of facility policy/procedure entitled, Restraints (Reviewed/Revised: 10/26/23) revealed, Policy: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. 1. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). An evaluation will be completed to determine the medical symptom requiring the device and to determine the least restrictive device to treat the symptom. 2. Restraints with locking devices shall not be used. 5. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or other emergency. 6. Physical restraints shall only be used on the signed order of a physician, except in an emergency which threatens to bring immediate injury to the resident or others. 7. Care plans which include the use of physical restraint for behavior control shall specify the behavior to be eliminated, the method to be used, and the time limit for the use of the method. 9. Residents shall be informed about the use of restraints as well as the negative outcomes of restraint use .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to update care plan interventions for two residents (Resident #55, Resident #124) of 22 residents reviewed, resulting in the likelihood for missed interventions in treatment and unmet needs. Findings include:Resident #55:In an interview on 01/27/2026 at 11:17 AM, Resident #55 stated that he has had a urinary catheter for years and basically takes care of it himself. He is on antibiotic for an irritated skin at the suprapubic site. He denied Urinary Tract Infection at this time but has had them in the past. The resident could not recall the facility staff education on catheter care provided to him. Observation on 01/27/2026 at 11:21 AM of Resident #55 was seated up in a wheelchair in his room and showed the surveyor his right catheter leg bag he puts on himself. Resident #55 was observed to be moving throughout the hallways in wheelchair self-propelling, will monitor the catheter hanging on his right leg throughout survey. Observation on 01/28/2026 at 9:54 AM of Resident #55 was Observed urinary catheter leg bag observed to right lower leg. Leg strap is noted above the catheter bag and below the bag. Record review on 1/27/2026 of Resident #55's 'Activity of Daily Living (ADL)' care plan noted the resident had self-care performance deficit related to non-traumatic intracerebral hemorrhage, syncope, muscle weakness, cognitive communication deficit. Interventions dated 12/10/2023 of toileting: supervision-resident at time prefers to empty his own catheter. An interview and records review on 1/28/2026 at 1:51PM during the infection control task line listings revealed that Resident #55 was put on antibiotic Bactrim because of skin irritation at suprapubic site. Record review on 1/27/2026 of Resident #55's 'Suprapubic catheter related to presence of urogenital implant, obstructive uropathy. Resident #55 performs own Cather care; staff will assist as needed. Care plan revised 1/28/2026 Record review of Resident #55's January 2026 Medication Administration Record (MAR) revealed the resident was started on 1/7/2026 on Bactrim DS oral 800/180mg give one tablet by mouth every 12 hours for suprapubic catheter infection for 7 days. Resident #124:Record review of Resident #124's Medication Administration Record (MAR) noted that on 1/20/2026 antibiotic Meropenem intravenous 1 gram every 8 hours for sepsis. Observation and interview on 01/27/2026 at 9:49 AM of Resident #124 was lying in bed, she stated that she has a belly tube and the IV in her right arm. Resident #124 showed the state surveyor her right upper arm and abdominal gastrointestinal tube site. Observation had no split sponge gauze dressing noted to the site.Observation and interview on 01/27/2026 at 11:06 AM with Licensed Practical Nurse (LPN) N Unit Manager observed Resident #124's right upper arm midline Peripheral Inserted Central Catheter (PICC), dressing dated 1/20/2026, dressing occlusive. LPN N stated Resident 124 just came back from the hospital on 1/19/2026, she went with a Urinary Tract Infection and is getting antibiotics. Resident #124 opened her eyes and shakes her head in response to questions. LPN N stated that the PICC line is due to be changed today, it should be every 7 days. Observation and interview on 01/28/2026 at 9:04 AM Therapy staff O and P of Resident #124's right upper arm PICC line dressing is dated 1/20/2026 and is the same dressing observed previous day. Observation and interview on 01/28/2026 at 9:10 AM with Registered Nurse C (RN), came into Resident #124's room to observe the Right arm PICC line dated 1/20/2026. It should be changed every 7 days. Record review of Resident #124's Care plans pages 1-33 revealed that there was no infection, antibiotic medication or Peripheral Inserted Central Catheter (PICC) line care plan. There were no interventions for care related to monitoring of infection (temperature), PICC line site care and treatment. Peg Tube Removal:In an interview on 01/28/2026 at 3:50 PM with Resident #124 was seated up in Wheelchair in the hallway and so happy she got her belly tube out, she went to the doctor, and they took out her feeding/peg tube out. She is so happy and tells everyone about it. Record review of Resident #124's Care Plans pages 1-33 revealed that the resident was at risk for bleeding or hemorrhage related to Aspirin therapy dated 11/4/2024. Interventions included: Observed for and report to MD as needed and signs & symptoms of abnormal bleeding . Gastrointestinal care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan related to complications related to her impaired gastrointestinal status secondary to: Acid reflux, fatty liver, gastrotomy (peg tube) status. Interventions included: report abdominal cramping, nausea or vomiting, stay up right after meals, observed abdominal pain, abdominal cramping, increase in abdominal girth, hyperactive/hypoactive bowel sounds, frequency, urgency and loose stools. Tube feed: administer enteral nutritional ordered, observe for complications, treatment to tube site per order. Observed and reported to physician/NP/PA any abdominal pain, distention, tenderness at tube site, nausea/vomiting . Observation and interview on 01/29/2026 at 1:52 PM with Licensed Practical Nurse (LPN) Wound care nurse H and state surveyor observation of Resident #124's abdomen. LPN H was not aware that the gastro/peg tube was removed yesterday on 1/28/26. Observation of a 4x4 covered with tape, no date on the dressing. Resident #124 stated that the hospital nurses put the dressing on it and no one's looked at it since. In an interview and record review on 01/29/2026 at 1:55 PM with the Director of Nursing (DON) I was not aware that Resident #124 had her peg tube removed yesterday. The DON did a record reviewing the Resident #124's progress notes and there was a transport note at 5:55AM of gastro appointment. The DON could not find the consultation packet that is supposed to come back with the transport staff. The DON stated, What is supposed to happen is the transport person gives the consult packet to the nurse the nurse lets the provider know and puts in the new orders. Record review of the medical record revealed no new orders were put in, record review of progress notes revealed no note upon return of peg tube removal. The DON stated that there should have been an abdomen assessment, drainage from dressing, pain assessment, erythremia at the site, and some sort of abdomen assessment. There were no new orders put in by the nurse, so we did not know of the tube removal. Record reviews of care plans still had tube feeding on the care plan and there was no assessment of the dressing or how long it was to leave in place or change the dressing. Record review of the facility 'Comprehensive Care Plan' policy, dated 6/30/2022, revealed it is the policy of the facility to develop and implement a comprehensive person-centered car plan for each resident, consistent with resident rights, including measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The care plan will describe at a minimum the following: Any services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the provision of services to maintain grooming and hygiene for one resident (Resident # 1) of two residents reviewed. Findings include:Resident #1: On 1/28/26 at 8:43 AM, Resident #1 was observed in their room. The Resident was in bed, positioned on their back. The Resident was unshaven and had an unkempt appearance with uncombed and chunks of unknown substances on their shirt. When spoke to, Resident #1 made eye contact and shook their head yes or no in response to questions. When asked if staff had assisted them to get cleaned up, Resident #1 shook their head no. Record review revealed Resident #1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), epilepsy, gastrostomy (surgical procedure where an opening is created through the abdominal wall to the stomach, anxiety, traumatic brain injury, and dementia. Review of the Minimum Data Set (MDS) dated [DATE] revealed the Resident was severely cognitively impaired and required supervision to moderate assistance to complete Activities of Daily Living (ADLs). Review of Resident #1's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #1) has an ADL self-care performance deficit related to decreased functional mobility and physical limitations. (Initiated: 12/26/24; Revised: 10/22/25). The care plan included the interventions:- Dressing: 1 person assist (Initiated: 12/27/24; Revised: 11/25/25)- Shower/Bath. 1 assist . Prefers no facial hair. (Initiated: 12/27/24; Revised: 11/20/25)- Transfers: one person assist (Initiated: 12/26/24; Revised: 11/25/25)- Toileting: one person assist (Initiated: 12/26/24; Revised: 11/25/25) On 1/29/26 at 2:13 PM, Resident #1 was observed laying in their room in bed. Their hair remained uncombed and they were unshaven. [NAME] colored flecks of what appeared to be dandruff were observed on the Resident's hair and shirt. Resident #1 appeared to be wearing the same maroon colored shirt they were wearing on 1/28/26. The shirt had unknown dark colored areas on it as well as chunks of unknown substances. When queried if they were wearing the same shirt, Resident #1 shook their head to indicate yes. Resident #1 proceeded to smell their shirt and indicated it smelled bad. Resident #1 then raised their arm for me to smell it. The shirt had a foul odor. Resident #1 then held up three fingers. When asked if they were saying they had been wearing the same shirt for three days, Resident #1 shook their head yes. When asked if staff had assisted them to get cleaned up, Resident #1 shook their head no. An interview was completed with Certified Nursing Assistant (CNA) DD on 1/29/26 at 2:15 PM. When queried if they were assigned to care for Resident #1, CNA DD confirmed they were. CNA DD was asked if Resident #1 had gotten cleaned up for the day and had oral care completed and stated, No, I'm going to do it later today. At 2:19 PM on 1/29/26, an observation and interview with Resident #1 was completed with the Director of Nursing (DON). Upon entering the room, Resident #1 informed the DON they had been wearing the same shirt for three days and that it smelled bad. After exiting Resident #1's room, the DON confirmed the Resident's poor hygiene/grooming and the visible substances on their hair and shirt. The DON stated Resident #1's lack of daily care was Not acceptable and they were embarrassed. The DON verbalized they would have a staff member assist the Resident. Review of facility policy/procedure entitled, Activities of Daily Living (ADLs) (Revised: 12/28/23) did not address the provision of daily ADL 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** Based on observation, interview and record review, the facility failed 1) Address a hunger strike for Resident #57, 2) Assess and monitor a new skin alteration for Resident #99, and 3) Ensure a quality of care of assessment and monitoring per professional standards for Resident #124, resulting in a lack of care coordination, documentation and assessments. Findings include: Resident #124: Record review of Resident #124's progress notes dated 1/19/2026 at 4:06 PM noted the resident returned from hospital and an assessment was completed. Record review of Resident #124's vital signs, dated 1/19/2026 at 3:32 PM, noted a forehead temperature of 101.3 degrees F. Record review of Resident #124's Medication Administration Record (MAR) noted that on 1/20/2026, an antibiotic Meropenem intravenous 1 gram every 8 hours for sepsis. Record review of Resident #124's readmission Minimum Data Set (MDS), dated [DATE], noted a female with Brief Interview of Mental Status (BIMS) score of 13 out of 15, cognitively intact. Active medical diagnoses included: hypertension, Gastroesophageal reflux disease, renal insufficiency, diabetes, seizures, malnutrition, anxiety, depression, schizophrenia, chronic obstructive pulmonary disease and sepsis (life threatening infection). Section N: Medications identified antibiotic, antiplatelet, and antipsychotic medications. In an observation and interview on 01/27/2026 at 9:49 AM, Resident #124 was lying in bed. She stated that she has a belly tube and the IV in her right arm. Resident #124 showed the state surveyor her right upper arm and abdominal gastrointestinal tube site. Observation revealed no split sponge gauze dressing noted to the site. Resident #124 was diaphoretic/sweaty in appearance and moisture noted to facial area and hair line. In an observation and interview on 01/27/2026 at 11:06 AM with Licensed Practical Nurse (LPN) N [Unit Manager], the surveyor observed Resident #124's right upper arm midline Peripheral Inserted Central Catheter (PICC), with a dressing dated 1/20/2026 and the dressing was occlusive. LPN N stated Resident 124 just came back from the hospital on 1/19/2026, she went with a Urinary Tract Infection and is getting antibiotics. Resident #124 opened her eyes and shakes her head in response to questions. LPN N stated that the PICC line is due to be changed today. It should be every 7 days. In an interview on 01/27/2026 at 12:44 PM, Nurse Practitioner (NP) Q revealed Resident #124 had a temperature and that he let the staff know and they got temperature of 102.6 degrees. NP Q stated that he just worries about Resident #124 because she is diabetic and has co-morbidities and complications. Resident #124 may need to get more antibiotics and needs a septic work up. She was sweaty when I was in seeing her earlier this morning. Record review of Resident #124's temperature vital sign log revealed on 1/19/2026 a temperature of 101.3 degrees upon admission. Resident #124's temperature was not documented as being checked again until 1/28/2026. Record review of the facility 'Abuse, Neglect and Exploitation' Policy, dated 1/10/2024, noted neglect means failure of the facility, its employees, or service providers to provide goods and services to a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Record review of Resident #124's Progress Notes, dated 1/27/2026 at 11:40 AM, noted the resident has a temperature of 102.6, altered mental status. Resident finished Intravenous antibiotics for sepsis. Resident was sent out to hospital. Record review of Resident #124's return from leave and transfer assessment of 1/27/2026 at 9:40 PM made no mention of the PICC line dressing being occlusive and intact, no was photo taken, and there were no measurements of length or arm diameter from hospital care. Resident #57: On 1/28/2026 at approximately 3:00 PM, Resident #57 shared he has been on a hunger strike since 12 AM today due to the way facility management treats their employees and their termination. Resident #57 was asked if he informed anyone of his intentions and he reported Business Officer Manager W is aware. On 1/28/2026 at 3:30 PM, a review was conducted of Resident #57's medical records and it revealed the resident readmitted to the facility on [DATE] with diagnoses that included Diabetes, Atrial Fibrillation, Kidney Disease, Hypertension and anxiety. The resident is his own person and able to make his needs known to staff. Further review of his chart yielded the following: Care Plan: (Resident #57) is at risk for endocrine complications related to his altered metabolic status secondary to diabetes.Monitor blood glucose levels per orders. There was nothing located in his care plan regarding his hunger strike. On 1/28/2026 at 4:00 PM, an interview was conducted with Business Officer Manager W regarding Resident #57's hunger strike. Manager W reported during her rounds this morning he shared he was not happy with the Administrator because of the loss of employees. Due to this, he is now on a hunger strike and has not eaten breakfast. Manager W reported they discussed this during their morning stand-up meeting. On 1/29/2026 at 8:40 AM, Nurse Practitioner A reported she was aware on 1/27/2026 of Resident #57's hunger strike as he informed her during a visit. She educated him on the possible negative outcomes and informed the management team who stated they would provide additional support services. Practitioner A stated the resident should have monitoring in place. 01/29/2026 at 10:16 AM, an interview was conducted with Registered Dietetic Technician X. She shared she checked in with Resident #57, and he expressed he was on a hunger strike due to his favorite employees being terminated. Technician X stated she was made aware of his intentions on Tuesday and assessed him on Wednesday. She was uncertain how serious staff were taking his hunger strike as many resident's order takeout. Upon evaluation he agreed to accept mighty shakes with each meal going forward. Technician X stated prior to leaving yesterday she emailed the Nurse Manager to request an order for Accu-Cheks given that he is diabetic, being administered metformin and not currently eating. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Combined with his other comorbidities could affect his health status. Review was conducted of his chart, and it was found his blood glucose levels were not being monitored and there was a practitioner note on 1/27/26 regarding the strike but no other monitoring efforts were located in his chart. Resident #57's FAR (Food Acceptance Record) was reviewed, and he did not eat on 1/27/2026 or 1/29/2026. On 1/27/2026 - dinner its documented as 240 Technician X stated it is assumed this is the amount of fluids that he drank as it does not make sense for percentage eaten. Upon review of the MAR (Medication Administration Record) it indicated he was administered both does of his Metformin on 1/27/26, 1/28/26 and the morning does on 1/29/26. On 1/29/2026 at 12:42 PM, Resident #57 stated he did not eat last night 1/28/2026 or this morning. He explained he had three mighty shakes yesterday evening after speaking with the dietitian and two this morning. Resident #57 stated he is still on his hunger strike. On 1/29/2026 at 1:00 PM, CNA (Certified Nursing Assistant) Y was asked if Resident #57 ate food during breakfast and she stated he did not. She stated he had a few might shakes but not food intake. CNA Y was asked to clarify her charting on his FAR from breakfast and she stated it was indicative the he drank 100% of the mighty shakes. Further review was completed of Resident #57's chart and it yielded the following: Progress Notes: Practitioner note -1/27/2026 at 0800: .He does report dissatisfaction with some facility issues, I am going on a hunger strike for one week because the facility has fired some of my favorite nurses and I am going to make a statement.IDT made aware and will offer additional support. It can be noted dietary evaluated Resident #57 on 1/28/2026 at 7:10 PM after he had not eaten for 48 hours. There were not any other assessments and monitoring of his hunger strike until this point. Blood Sugar Summary: Resident #57's blood sugar was last checked on 1/1/2026 and was 109. January 2026 FAR: 1/27/2026: Breakfast- refused Lunch – refused Dinner – 240 (per Registered Dietetic Technician X believes this is fluid intake not amount eaten) 1/28/2026: Breakfast- refused (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lunch – refused Dinner: 60 (per Resident #57 he did not eat only drank mighty shakes) 1/29/2026: Breakfast- 100 Lunch – 50 Per CNA Y 1/29/26 documentation is indicative of amount of fluid intake. January 2026 MAR: Metformin HCl Tablet 500 MG – give one tablet by mouth every morning and at bedtime. Resident #57 was administered both doses on 1/27/26 and 1/28/26. On 1/29/26 he was administered his morning dose. Review was completed of the facility policy entitled, Resident Meal Service, reviewed 7/1/2025. The policy stated, .Significant variations from usual eating or intake patterns must be recorded in resident's record. The Nurse Supervisor and/or Unit Manager shall evaluate the significance of such information and report it, as indicated, to the Attending Physician and Dietitian. Resident #99: On 1/27/2026 at 11:10 AM, Resident #99 was observed in bed and reported he was awaiting his therapy session. Observed on his fitted sheet, top sheet and blanket were dark red circular spots and multiple areas of splattered red stains. Resident #99 reported it was from his bilateral legs bleeding. On his left forearm was a large bandage that was undated or initiated. The resident reported he has an area that continues to bleed and the staff have been bandaging it for the past three days. On 1/27/2026 at 12:36 PM, Nurse S stated she was unaware of any bandages on his arms. She reviewed Resident #99's progress notes and treatment orders and shared there was nothing listed regarding this. CNA (Certified Nursing Assistant) U shared on yesterday the nurse was attempting to get ahold of the Wound Nurse H to assess Resident #99's arm as it kept bleeding through the bandages. He had gone through two bandages prior to the nurses placing xeroform, folding a 4x4 gauze in half twice and securing with boarder gauze. From their understanding Wound Nurse H never came down to assess the area. On 1/27/2026 at approximately 12:55 PM, Wound Nurse H was queried if staff asked her to assess Resident #99's forearm yesterday and if she was aware of the new skin alteration. Nurse H reported she was unaware of this, and no staff asked her to assess any skin issues for him yesterday. Nurse H was asked if she would be able to assess and she reported she would go right down. On 1/27/2026 at 1:00 PM, an interview was conducted with Nurse R regarding Resident #99's forearm. She explained upon arriving for her shift the residents left forearm was already bandaged. She reviewed his chart and did not see a treatment order or any notes regarding the reasoning for the bandage or subsequent skin alteration. Nurse R reported she contacted Wound Nurse H and asked her (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to assess the area but she informed her to reinforce the dressings. Nurse H never came down to assess Resident #99's forearm. Review of text message exchange between Nurse R and Wound Nurse H on 1/26/2026 at 12:36 PM: Nurse R: 102 has a bunch of bandages on his arms and hands. I don't' have orders visible. Can you come down for further instruction? I never knew him to have them. Wound Nurse H: He picks at his skin. U can remove, if there is no drainage leave them off. Nurse R: He's bleeding, soaking through them to be exact. I'll change them. Wound Nurse H: Face palm emoji On 1/27/2026 at 1:20 PM, Wound Nurse H was asked if she had a text exchange with a nurse regarding Resident #99's bandages. Wound Nurse H asked which nurse and then stated, Was is (Nurse R)? Nurse H proceeded to recant her earlier account and reported she did not recall speaking to Nurse R regarding this as she receives so many text messages a day. Nurse H did not have an answer when asked why she hurriedly went to assess the resident when asked by this surveyor but did not assess the day prior when requested by nursing staff. On 1/27/2026 at approximately 3:30 PM, a review was conducted of Resident #99's medical records and it revealed he readmitted to the facility on [DATE] with diagnosis that included, Congestive Heart Failure, Diabetes, Atrial Fibrillation, Insomnia, Major Depressive Disorder and Peripheral Vascular Disease. TAR (Treatment Administration Record): January 2026: The TAR indicated treatment orders were first entered on 1/27/2026 at 1:15 PM for his left inner forearm wound. Which was after the discussion with the facility regarding this concern. Care Plan: . (Resident #99) is at risk for abnormal bleeding or hemorrhage related to anticoagulant therapy, aspirin therapy and antiplatelet therapy. On 1/29/2026 at 8:40 AM, Nurse Practitioner A reported Resident #99 does pick at his skin and a request for their psychiatric group to evaluate him will be placed. Practitioner A stated any wound care treatment should be an order and if staff observed a new skin alteration, they reach out to Wound Care Nurse H for assessment and appropriate order.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to follow standards of practice by failing to assess and monitor the removal site of a gastrostomy tube (GT) site and monitor pain for one resident (Resident #124) of 3 residents reviewed for tube feeding in a sample of 22 residents. Finding include:Resident #124:Peg Tube Removal:In an observation and interview on 01/27/2026 at 9:49 AM, Resident #124 was lying in bed. She stated that she has a belly tube and the IV in her right arm. Resident #124 showed the state surveyor her right upper arm and abdominal gastrointestinal tube site. Observation revealed no split sponge gauze dressing noted to the site.In an interview on 01/28/2026 at 3:50 PM, Resident #124 was seated up in Wheelchair in the hallway and was so happy she got her belly tube out. She went to the doctor, and they took out her feeding/peg tube. She is so happy and tells everyone about it. Record review of the facility 'Nutritional Management' policy, dated 7/1/2025, revealed the facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. (5.) (c.) The care plan will be updated as needed, such as when a resident's condition changes . Record review of Resident #124's Care Plans, Pages 1-33 revealed that the resident was at risk for bleeding or hemorrhage related to Aspirin therapy dated 11/4/2024. Interventions included: Observed for and report to MD as needed and signs & symptoms of abnormal bleeding . Gastrointestinal care plan related to complications related to her impaired gastrointestinal status secondary to: Acid reflux, fatty liver, gastrotomy (peg tube) status. Interventions included: report abdominal cramping, nausea or vomiting, stay up right after meals, observed abdominal pain, abdominal cramping, increase in abdominal girth, hyperactive/hypoactive bowel sounds, frequency, urgency and loose stools. Tube feed: administer enteral nutritional ordered, observe for complications, treatment to tube site per order. Observed and reported to physician/NP/PA any abdominal pain, distention, tenderness at tube site, nausea/vomiting . In an observation and interview on 01/29/2026 at 1:52 PM with Licensed Practical Nurse (LPN) H (wound care nurse), the state surveyor observed Resident #124's abdomen. LPN H was not aware that the gastro/peg tube was removed yesterday on 1/28/26. Observation of a 4x4 covered with tape, no date on the dressing. Resident #124 stated that the hospital nurses put the dressing on it and no one's looked at it since. In an interview and record review on 01/29/2026 at 1:55 PM, the Director of Nursing (DON) I was not aware that Resident #124 had her peg tube removed yesterday. The DON did a record review of Resident #124's progress notes and there was a transport note at 5:55AM of a gastro appointment. The DON could not find the consultation packet that is supposed to come back with the transport staff. The DON stated, What is supposed to happen is the transport person gives the consult packet to the nurse the nurse lets the provider know and puts in the new orders. Record review of the medical record revealed no new orders were put in. Record review of the progress notes revealed no note upon return of peg tube removal. The DON stated that there should have been an abdomen assessment, drainage from dressing, pain assessment, erythremia at the site, and some sort of abdomen assessment. There were no new orders put in by the nurse, so we did not know of the tube removal. Record reviews of care plans still had tube feeding on the care plan and there was no assessment of the dressing or how long it was to be in place or when to change the dressing. Record review of Resident #124's 'Skilled Daily' document, dated 1/29/2026 at 3:41AM, noted that the PEG tube was removed. Record review of the facility 'Pain Management' Policy, dated 10/23/2023, revealed that the facility will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice . Recognition: Evaluate the resident for pain upon admission, during ongoing scheduled assessments and with change in condition to status . Pain Assessment: An assessment or evaluation of pain based on professional standards of practice by appropriate members of the interdisciplinary team . Review of the resident's diagnosis or conditions and any additional factors that may be causing or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 West Vienna Road Montrose, MI 48457

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contributing to pain . Duration, frequency, location, onset, pattern, radiation .Aching, burning, throbbing, tingling, stabbing .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	02/02/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for storage and cleaning of respiratory equipment for one resident (Resident #1) of three residents reviewed, resulting in a lack of cleaning and appropriate storage of nebulizer (machine which converts liquid into fine mist for administrator of medications directly into the lungs through respiration) equipment. Findings include:Resident #1: On 1/28/26 at 8:43 AM, Resident #1 was observed in their room in bed. When spoke to, Resident #1 would make eye contact and shook their head yes or no in response to questions. A nebulizer machine was observed on the dresser beside the Resident's bed. A nebulizer administration mask was sitting next to the machine on the dresser in a clear bag. The nebulizer mask was connected in the bag and visible fluid was present in the medication administration chamber. An oxygen concentrator was present with nasal canula tubing connected. The nasal cannula tubing was uncontained and sitting on top of multiple items on the dresser. Record review revealed Resident #1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), epilepsy, gastrostomy (surgical procedure where an opening is created through the abdominal wall to the stomach, anxiety, traumatic brain injury, and dementia. Review of the Minimum Data Set (MDS) dated [DATE] revealed the Resident was severely cognitively impaired and required supervision to moderate assistance to complete Activities of Daily Living (ADL). On 1/29/26 at 7:51 AM, Resident #1's nebulizer face mask was observed sitting in the same position, in a clear bag, on top of their dresser. The nebulizer mask was connected in the bag with visible fluid present in the medication administration chamber. Unit Manager Licensed Practical Nurse (LPN) N was observed in the hallway and asked to come into Resident #1's room. LPN N was shown the medication administration mask set with the visible fluid in the medication chamber and informed the mask and fluid were observed in the same position on 1/28/26. LPN N stated, It shouldn't be left together with fluid in the chamber. When queried regarding appropriate care and storage of nebulizer equipment, LPN N replied, Should be taken apart and cleaned. Review of facility policy/procedure entitled, Nebulizer Therapy (Reviewed/Revised: 5/15/24) revealed, It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions. p. Disassemble and rinse the nebulizer water and allow to air dry. 2. Care of the Equipment a. Clean after each use. c. Disassemble parts after every treatment. d. Rinse the nebulizer cup and mouthpiece with water. e. Shake off excess water. f. Air dry on an absorbent towel. g. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. h. Change nebulizer tubing weekly.