STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235611	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Creek Skilled Nursing	9731 East Cherry Bend Road Traverse City, MI 49684

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from neglect by facility staff for one Resident (#4) of one residents reviewed for abuse and neglect. This deficient practice resulted in actual harm when Resident #4 experienced unnecessary pain and persistent feelings of fear and anxiety.Findings include:Resident #4 (R4) Review of R4's Electronic Medical Record (EMR) revealed initial admission to the facility on 8/13/25 with diagnoses including congestive heart failure, difficulty in walking, and pain in right shoulder. Review of R4's most recent Minimum Data Set (MDS) assessment, dated 8/25/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. On 9/2/2025 at 12:22 PM, an interview was conducted with R4 regarding their satisfaction with the level of care they were receiving at the facility. R4 stated a couple nights ago she needed to use the restroom while in bed, so a certified nursing assistant (CNA) placed her on a bedpan at 5:00 AM. R4 recalled, They [the CNA] didn't leave me a button pusher [call-light], so I was on the bedpan until 7:00 AM. The door was closed. I couldn't get to it [the call-light] . So, it was two hours I laid here. When asked if they experienced pain from the extended period on top the bed pan, R4 stated, Well, yeah! I can't use my right arm at all. I finally got the bed pan from under me with the left hand. I was very uncomfortable. Review of R4's Medication Administration Record (MAR) revealed the following order: Oxycodone HCl Oral Tablet 10 MG (milligram), give 1 tablet by mouth every 4 hours as needed for severe pain. A dosage of oxycodone was administered on 8/30/25 at 9:48 AM for a recorded pain level of 10/10. Review of R4's EMR revealed an interdisciplinary team (IDT) meeting note, dated 8/27/25 at 14:58 [2:58 PM], read, in part: .Bed mobility: modA [moderate assistance]. Toileting: [NAME] [maximum assistance].10/10 pain arthritis in R [right] shoulder. On 9/04/2025 at 7:21 AM, a follow-up interview was conducted with R4 who admitted she still thought about the event. R4 stated, It was scary . I didn't have my buzzer [call-light] or anything. I'm concerned it might happen again. On 9/3/25 at approximately 11:30 AM, an interview was conducted with Certified Nurse Aide (CNA) K who verified that she was the oncoming aide to be working with R4 the morning of 8/30/25. CNA K (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 0600 Level of Harm - Actual harm Residents Affected - Few	stated that she came into R4's room around 6:45-7:00 AM to obtain a set of vitals when she observed the bed pan on R4's bed. CNA K stated, She (R4) told me that the bed pan was placed under her at 5:00 AM, she couldn't ring for help because she didn't have a call light, and she had to remove the bed pan herself which caused her a lot of pain. I ended up calling the night shift who don't remember putting a bed pan underneath her, but she (R4) is not able to do it herself. Everything (R4) is telling you is true. On 9/4/2025 at 10:11 AM, an interview was conducted with Licensed Practical Nurse (LPN) C who verified she was working at the time R4 was left on the bedpan. LPN C stated she was aware the bedpan was left under R4 for an extended period but was unaware of the exact duration. LPN C recalled when she entered R4's room, It [the bedpan] was pushed to the side of the bed, kind of halfway out from beneath her [R4]. When asked if she conducted a skin assessment to verify no breaches in skin integrity, LPN C stated, It was dark [in R4's room]. I helped her get cleaned up, but I didn't see much. LPN C stated she did not report the event to the Director of Nursing (DON) but may have informed the oncoming nurse during shift change. On 9/4/2025 at 11:22 AM, an interview was conducted with the DON regarding the incident with R4. The DON stated she was unaware of the incident as it was never reported to her. When asked if it should have been reported the DON stated, Yes, I would have investigated it. The DON verified a call-light should always be placed within reach of a resident when a staff member exits a resident room. When asked about possible adverse outcomes of a resident spending approximately two hours on a bedpan the DON replied, Well, she's [R4] already got a mark on her bottom . she's got a stage one [pressure ulcer], I think. Review of a document titled, Wound Evaluation, dated 8/28/25, read, in part: Pressure – Stage 1. Body Location: Coccyx. Acquired: In-House Acquired. Review of a document titled, Wound Evaluation, dated 8/30/25, read, in part: Pressure – Stage 2. Body Location: Coccyx. Acquired: In-House Acquired. Progress: Deteriorating. Review of the facility's Abuse, Neglect, Misappropriation or Exploitation Policy/Procedure, undated, read, in part, .The res resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.It is the responsibility of our employees.to immediately report any witnessed, reported, alleged or suspected incident of abuse, neglect, misappropriation of resident property, and exploitation to the Administrator and Director of Nursing.Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate staffing to promote the physical, mental, and psychosocial well-being of residents. Findings include: On 9/3/25 at approximately 11:30 a.m. an interview was conducted with Certified Nurse Aides (CNA) J and K in regard to complaints of low staffing numbers. CNAs J and K confirmed that during shift change, residents can wait 30 to 45 minutes after report for staff to come and assist. CNA K stated, Sometimes it can be up to 45 minutes before we are out on the floor and then we have to get people up, get them dressed, toilet, vitals, breakfast, etc. When there are only two of us, it can be a challenge, and they (residents) have to wait a long time. Both CNA J and K confirmed that the current population of residents is requiring more lifts and two person transfers, which causes them both to tend to one resident at a time. CNA J stated, We don't have enough (staff), with the high number of residents who need two staff assistance, it isn't enough. Review of the facility's assessment, last reviewed 8/6/24, revealed the required number of staff per census in the facility yielded results as follows: Staffing Levels Based on Census, Diagnosis, Resident Acuity and (Facility Name) Staff Experience: Certified Nursing Assistants 20 Census 6-2 (6:00 a.m. to 2:00 p.m.)shift = 4 CENA 2-10 (2:000 p.m. to 10 p.m.) shift = 310-6 (10 p.m. to 6 a.m.) shift = 2 16 Census 6-2 (6:00 a.m. to 2 p.m.) shift = 3 CENA 2-10 (2 p.m. to 10 p.m.) shift = 210-6 (10 p.m. to 6 a.m.) shift = 2 A request of the daily working schedules for CNA's revealed that the facility did not follow their staff levels based on their assessment: 8/17/25 two CNA's from 6 a.m. – 10 a.m. census at facility 178/21/25 two CNA's from 6 a.m. – 2 p.m. census at facility 16 8/28/25 three CNA's from 6 a.m. – 2 p.m. census at facility 20 8/29/25 three CNA's from 6 a.m. – 2 p.m. census at facility 20 An interview was conducted with the Director of Nursing (DON) on 9/4/25 at approximately 11:20 a.m. The DON reviewed the daily staffing sheets along with the facility assessment and confirmed that the facility did not follow the required staffing levels. Resident #4 (R4) Review of R4's Electronic Medical Record (EMR) revealed initial admission to the facility on 8/13/25 with diagnoses including congestive heart failure, difficulty in walking, and pain in right shoulder. Review of R4's most recent Minimum Data Set (MDS) assessment, dated 8/25/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. On 9/2/2025 at 12:22 PM, an interview was conducted with R4 regarding their satisfaction with the level of care they were receiving at the facility. R4 stated a couple nights ago she needed to use the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	restroom while in bed, so a certified nursing assistant (CNA) placed her on a bedpan at 5:00 AM. R4 recalled, They [the CNA] didn't leave me a button pusher [call-light], so I was on the bedpan until 7:00 AM. The door was closed. I couldn't get to it [the call-light] . So, it was two hours I laid here. When asked if they experienced pain from the extended period on top the bed pain, R4 stated, Well, yeah! I can't use my right arm at all. I finally got the bed pan from under me with the left hand. I was very uncomfortable. When asked if staffing levels were sufficient, R4 replied, I can go into the bathroom and sit there for 20 or 30 minutes . I know they don't have enough help. Review of R4's EMR revealed an interdisciplinary team (IDT) meeting note dated 8/27/25 at 2:58 pm, which read, in part: .Bed mobility: modA [moderate assistance]. Transfers: Max [maximum assistance].Toileting: [NAME]. Resident #17 (R17) Review of R17's EMR revealed initial admission to the facility on 7/1/25 with diagnoses including cerebral infarction (stroke) and vascular dementia. Review of R17's most recent MDS assessment, dated 7/15/25, revealed she required moderative assistance with bed mobility, toileting hygiene, toilet transfers, and ambulating ten feet. On 9/3/2025 at 10:06 AM, a phone interview was conducted with R17's Durable Power of Attorney (DPOA) H who stated she visited the facility every-other-day. When asked her perception of the facility staffing levels, DPOA H responded, If my mom (R17) needs something like using the bathroom, especially around mealtimes or shift changes, I don't even bother [using the call-light]. I'll just take her to the toilet myself. Review of the [Provider Name] Facility Assessment, reviewed 8/6/24, read, in part: .Primary Services and Care Offered: . Bowel/bladder: Toileting schedules, urinary assessment, use of intermittent and indwelling urinary catheters, ostomy care, peri-care, 2 hour incontinent checks, encouraging resident's independence/assist with care, providing and assisting with resident's requests to use the bathroom/toilet promptly in order to maintain continence and dignity .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety as evidenced by:Failing to label, date, and discard expired food in the reach-in refrigerator, walk-in refrigerator, walk-in freezer, and dry storage. Failing to ensure kitchen utensils were stored in a sanitary manner.Failing to ensure the ice cube machine/bin was free from mold accumulation.These deficient practices have the potential to result in food borne illness among any or all of the 17 residents in the facility.Findings include: On 9/2/25 at 11:24 PM, an initial tour of the kitchen was conducted with Dietary Manager (DM) G. The following observations were made in the reach-in refrigerator: Undated, unidentifiable meat in a plastic tub covered with plastic wrap. DM G identified this as sliced steak from the previous day's lunch meal. A bowl of what appeared to be cooked onion rings, covered with plastic wrap, undated. A bowl of cubed pineapple, covered in plastic wrap, undated. Two bagels in an unsecured bag, undated. An uncovered, undated sandwich sitting on a plate. On 9/2/25 at 11:29 PM, the following observations were made in the reach-in freezer: Unidentified meat patties, in an unzipped bag, undated Undated, pre-prepared chicken patties. During the kitchen tour on 9/3/25 at 9:00 AM the following deficiencies were noted: All foods stored in the reach in refrigerator were not properly labeled with a use by date (UBD) Two containers of clam flavored soup base located in the walk-in refrigerator were expired in December 2024. Mold was observed inside the ice machine located near the dry storage room. All foods located in the reach in freezer were not properly labeled with a UBD. A bag of frozen cookies stored in a Ziplock style bag were not properly sealed. Bread rolls and Danish pastries located on the bread rack did not have a date opened/made or a UBD. A storage drawer was observed to have copious amounts of crumbs touching multiple kitchen utensils. An interview with Dietary Manager (DM) G on 9/4/25 at 10:12 a.m. confirmed that staff do not label (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	foods with a UBD. DM G also confirmed that the expired foods should have been properly disposed, and the kitchen should be kept in a clean sanitary manner. Review of the Food and Drug Administration (FDA) 2017 Food Code, read, in part, 4-602.11 Equipment Food-Contact Surfaces and Utensils.ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms. 6-405.10 Receptacles, Waste Handling Units, and Designated Storage Areas.Waste materials and empty product containers are unclean and can be an attractant to insects and rodents. Food, equipment, utensils, linens, and single-service and singleuse articles must be protected from exposure to filth and unclean conditions and other contaminants. 3-5 LIMITATION OF GROWTH OF ORGANISMS OF PUBLIC HEALTH CONCERN .(D) A date marking system that meets the criteria stated in ¶¶ (A) and (B) of this section may include: (1) Using a method APPROVED by the REGULATORY AUTHORITY for refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to annually review and update the required Facility Assessment, resulting in the potential for unidentified resources necessary to provide care and services to the resident population.Findings include: Review of the Facility Assessment document provided by the facility revealed the Facility Assessment was last completed, updated, or reviewed on 8/6/24.In an interview on 9/4/25 at approximately 11:30 AM, the Nursing Home Administrator (NHA) confirmed that the Facility Assessment had not been completed, updated, or reviewed since 8/6/24.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain complete and comprehensive informed consents prior to the administration of psychotropic medications for three Residents (#4, #17, and #20) of five residents reviewed for unnecessary medications.Findings include:Resident #17 (R17)Review of R17's electronic medical record (EMR) revealed initial admission to the facility on 7/1/25 with diagnoses including cerebral infarction (stroke) and vascular dementia. Review of R17's most recent Minimum Data Set (MDS) assessment, dated 7/15/25, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment.Review of R17's EMR revealed the following pharmacy order, initiated 7/1/25: Duloxetine HCl Oral Capsule Delayed Release Particles 60 MG (milligram) [an antidepressant (psychotropic) medication], Give 1 capsule by mouth two times a day for depression/pain.Review of R17's EMR revealed a document titled, Consent for Psychoactive Medications which read, in part: The resident's provider has ordered the following psychoactive medications. Duloxetine. Do you consent to the use of the above medications? The following area had a space for the resident or responsible party to select, Yes or, No.Further review of the form revealed it was signed by both the R17 and their Durable Power of Attorney (DPOA), but the consent to treatment had not been checked.Resident #20 (R20)Review of R20's EMR revealed initial admission to the facility on 7/14/25 with diagnoses including left shoulder dislocation and chronic kidney disease.Review of R20's EMR revealed the following pharmacy order, initiated 7/22/25: Duloxetine HCl Oral Capsule Delayed Release Particles 20 MG (Duloxetine HCl), Give 2 capsule by mouth at bedtime for pain.Review of R20's EMR revealed a document titled, Consent for Psychoactive Medications which read, in part: The resident's provider has ordered the following psychoactive medications. Duloxetine. Do you consent to the use of the above medications? The following area had a space for the resident or responsible party to select, Yes or, No.Further review of the form revealed it was signed by R20 but the consent to treatment had not been checked.Resident #4 (R4)Review of R4's EMR revealed initial admission to the facility on 8/13/25 with diagnoses including congestive heart failure and localized edema.Review of R4's EMR revealed the following pharmacy orders, initiated 8/13/25: Escitalopram Oxalate Oral Tablet 5 MG [an antidepressant (psychotropic) medication], Give 1 tablet by mouth one time a day for depression. Buspirone HCl Oral Tablet 5 MG [an anti-anxiety (psychotropic) medication], Give 1 tablet by mouth three times a day for anxiety.Review of R4's EMR revealed a document titled, Consent for Psychoactive Medications which read, in part: The resident's provider has ordered the following psychoactive medications. Buspirone, Escitalopram. Do you consent to the use of the above medications? The following area had a space for the resident or responsible party to select, Yes or, No.Further review of the form revealed it was signed by R4 but the consent to treatment had not been checked.On 9/4/2025 at 10:26 AM, an interview was conducted with Assistant Director of Nursing (ADON) A regarding her expectations for completeness of psychotropic consent forms. ADON A stated each form should indicate if the individual consented or declined the psychotropic medication by either checking yes or no. ADON A stated, I need to provide additional education to the nursing staff to ensure the form is completed.Review of the facility policy titled, Antipsychotic Medication Use, undated, read, in part: .residents who are receiving a psychoactive medication will also require a consent for the use of the medication signed by the resident of responsible party.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assure that procedures were developed and implemented for consistent and accurate processing of medication orders for two Residents (#8 and #15) of six residents reviewed for pharmacy services. This deficiency resulted in Resident #8 being administered the incorrect dosage of an anxiolytic medication and the potential for the inaccurate administration of an anticoagulant for Resident #15. Findings include: Resident #8 (R8)Review of the Minimum Data Set (MDS) assessment, dated 3/24/2025, revealed R8 was admitted to the facility on [DATE] and had diagnoses including coronary artery disease, chronic obstructive respiratory disease (COPD) and anxiety.Review of R8's March 2025 medication administration record (MAR) revealed the following orders: Ativan (a controlled medication used to treat anxiety) Oral Tablet 1 MG [milligram] . Give 4 tablet[s] by mouth every 4 hours for anxiety. Start Date: 3/19/2025 1800 [6:00 PM]. D/C [discontinued] Date: 3/20/2025 1305 [1:05 PM]. Further review revealed the medication was documented as administered on 3/20/2025 at 10:00 AM. Ativan Oral Tablet 2 MG. Give 2 tablet[s] by mouth every 4 hours for anxiety/restlessness. Start Date: 3/19/2025 0200 [2:00 AM]. Hold Date: From 3/19/2025 1545 [3:45 PM] to 3/20/2025 1304 [1:04 PM]. D/C Date: 3/20/2025 1306 [1:06 PM].Review of a Medication Related Incident Report, dated 3/20/2025 and gleaned from R8's electronic medical record (EMR) revealed the following: 3/20/2025 10:00 AM. Incident Type: Wrong dose. Did an adverse drug reaction occur as a result of the medication error? Yes . On 3/19/25 only 1mg [Ativan] tablets available. Order read Ativan 1mg x 4 tabs q4h [every four hours]. 3/20/25: 2mg Ativan tabs available. Order not updated to reflect strength change of tablets. Nurse gave 4 - 2mg tablets [at] 10:00 AM on 3/20/25.On 9/4/2025 at 10:00 AM, the Director of Nursing (DON) reported the error which resulted from the pharmacy sending higher strength tablets of the Ativan in the form of 2mg tablets with new instructions to give two tablets every four hours. The DON presented R18's Ativan Controlled Medication Dispensing Logs, which revealed the following: Lorazepam [Ativan] 1MG Tablet. Take 4 tablets (4MG) by mouth every four hours (take until 2MG tablets are in stock).The DON reported she believed the nurse was distracted by activity within the facility at the time of administration and due to the order not being reconciled with the pharmacy recommendation, and the order for Ativan 1mg tablets not being discontinued upon receipts of the Ativan 2mg tablets, the incorrect amount of Ativan was administered.Resident #15 (R15)Review of the MDS assessment, dated 8/25/2025, revealed R15 was admitted to the facility on [DATE] and had diagnoses including atrial fibrillation (a-fib), an open, abdominal skin ulcer and necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin).Review of R15's EMR revealed a Warfarin Dosing Form, signed by Pharmacist I and dated 9/2/2025, revealed the following: Current warfarin dose: Warfarin (Coumadin, a medication used to inhibit the rate of blood clotting, a blood thinner] 5mg M/W [Mondays and Wednesdays]; 2.5mg all other days.Further review of the Warfarin Dosing Form, revealed R15's INR (International Normalized Ratio, a blood test to determine the effectiveness of blood-thinning medications) was reported as 2.7 on 9/02/2025 and Pharmacist I recommended the following: Recommended Dose: Start warfarin 5mg Wed [Wednesday]; 2.5mg all other days. Next INR: Monday 9/8/25.It was noted in review of R15's EMR and the Warfarin Dosing Form, there was no indication on the form of when the recommendation was received or who the recommendation was reviewed by at the facility.Review of R15's medication orders was conducted on 9/3/2025 at 10:15 AM and revealed the following orders for Resident's warfarin dosing in response to the pharmacist's recommendation on 9/2/2025: Warfarin sodium Oral Tablet 5 MG. Give 1 tablet by mouth at bedtime every Mon [Monday], Wed [Wednesday] for coag [coagulation]. Start Date: 8/27/2025 2000 [8:00 PM]. D/C [discontinued] Date: 9/02/2025 1505 [3:05 PM]; warfarin sodium Oral Tablet 2.5 MG. Give 1 tablet by mouth at bedtime every Tue [Tuesday], Thu [Thursday], Fri [Friday], Sat [Saturday], (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sun [Sunday] for treating/preventing blood clots. Start Date: 8/26/2025 2000 [8:00 PM]. D/C Date: 9/02/2025 1506 [3:06 PM]. Warfarin sodium Oral Tablet 5MG. Give 1 tablet by mouth at bedtime every Mon [Monday], Wed [Wednesday] for coag [coagulation]. Start Date: 9/03/2025 2000 [8:00 PM]; warfarin sodium Oral Tablet 2.5 MG. Give 1 tablet by mouth at bedtime every Tue [Tuesday], Thu [Thursday], Fri [Friday], Sat [Saturday], Sun [Sunday] for treating/preventing blood clots. Start Date: 9/02/2025 2000 [8:00 PM].Review of R15's September 2025 MAR revealed the order for warfarin 5mg did not reflect the current recommendation issued by the pharmacist on 9/02/2025 to decrease the dosage to warfarin 5mg on Wednesdays only and 2.5mg on all other days of the week.During an interview on 9/4/2025 at 8:45 AM, the DON reported the pharmacy dosed resident's warfarin dosages based on INR results. The DON reviewed R15's 9/2/2025 pharmacy recommendation for warfarin dosing and confirmed the dosage should have been changed to reflect the recommendation to decrease the dosage to 5mg on Wednesdays only and 2.5mg all other days of the week. When asked what the process was for reviewing the pharmacy recommendations, the DON could not articulate the facility procedure for a specific staff person responsible for receiving and reviewing pharmacy recommendations. The DON stated the nurses on duty at the time the Warfarin Dosing Form, was received should an act on the recommendations and obtain additional verification by a second nurse.During interview on 9/4/2025 at 9:20 AM, Assistant Director of Nursing (ADON) A reported pharmacy recommendations are reviewed by nurses on the night shift. After review and follow through on the recommendations, the Warfarin Dosing Forms, are added to the documents to be scanned into the EMR. ADON A stated she attempted to review all pharmacy recommendations for completion and accuracy but had not been able to get around to verifying the pharmacy recommendations and orders regarding R15's warfarin dosing for the current week. When asked if the facility had a policy related to receiving, reviewing and response to pharmacy recommendations, ADON A reported, not that I am aware of.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235611	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assure the implementation of Enhanced Barrier Precautions (EBP) according to physician order and current standards of practice for two Residents (#10 and #18) of four residents reviewed for EBP utilization.Findings include:Resident #10 (R10)Review of the Minimum Data Set (MDS) assessment, dated 9/8/2025, revealed R10 was admitted to the facility on [DATE] and had diagnoses including left femur fracture, breast cancer and anxiety. Further review of the MDS assessment revealed R10 required substantial/maximal assistance with bathing, lower body dressing and transfers, and partial/moderate assistance with toileting hygiene.Review of R10's electronic medical record revealed R10 had a Stage 2 (partial-thickness tissue loss) pressure injury to her spine. Review of R10's Wound Evaluation, dated 8/31/2025, revealed the pressure injury measured 0.67 centimeters (cm) in length and 0.51 cm in width. Review of the photograph attached to the Wound Evaluation, revealed an area of redness over R10's spinous process located mid-back. The center of the reddened area was open with a depth of approximately 0.5 cm and a white wound bed.Review of R10's physician orders revealed the following, active order: Follow EBP guidelines during wound and foley care as well as during high contacts resident care activities (dressing, showering, transferring, changing linens or briefs . Active 8/22/2025.An observation of R10's wound care was conducted on 9/4/2025 at 7:50 AM. During care, Licensed Practical Nurse (LPN) C was observed removing a two inch by two inch (2x2) bordered foam dressing from R10's mid back to reveal a round open area, approximately 0.5 cm in diameter. LPN C cleansed the wound with wound cleanser, applied skin prep and covered the area with a clean bordered foam dressing. It was noted during wound care LPN C wore gloves but did not where a protective gown.Immediately following the wound care observation, R10 requested assistance to use the toilet. LPN C and Certified Nursing Assistant (CNA) D were observed transferring R10 from her wheelchair to the toilet using a sit-to-stand lift. CNA D was observed to assist R10 with toileting hygiene and both CNA D and LPN C transferred R10 from the toilet to her wheelchair. It was noted in observation, neither LPN C or CNA D wore protective gowns in the care of R10.During an interview immediately following the observation, CNA D was queried as to when the use of enhanced barrier precautions (EBP) was necessary in the care of residents. CNA D reported EBP would be utilized if there was a sign posted alerting staff for the need of EBP. CNA D stated, like for resident with wounds, catheters or IVs [intravenous lines].During an interview on 9/04/2025 at 8:30 AM, LPN C was queried about what the indications were for the use of EBP in resident care. LPN C confirmed she should have implemented the use of EBP during wound care and toileting of R10. LPN C reported a sign should have been posted in the doorway of R10's room alerting staff to the need to use EBP. An observation at the time of the interview revealed no EBP signage present in R10's doorway. During the interview, the Assistant Director of Nursing (ADON), who also served as the facility's Infection Preventionist, reported she was unsure why there was no sign posted for the use of EBP in R10's care. The ADON confirmed EBP was ordered for the care of R10 due to her having an open wound.Further observation at the time of the interview revealed Resident #18 (R18) calling out from his room for assistance. Upon hearing R18, LPN C was observed entering R18's room and assisting the resident to reposition his legs and feet before proceeded to adjust R18's bedding to cover the Resident. During the observation, it was noted R18 had urinary catheter tubing leading from the Resident to a dependent drainage bag attached to the left lower bedframe. LPN C did not wear a protective gown during care provision for R18. A sign was observed to be attached to the doorway to R18's room alerting staff to the need for EBP during all high contact care activities. Further review of the sign revealed the following: Enhanced Barrier Precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities . providing hygiene, changing briefs and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisting with toileting, device care or use: . feeding tube . wound care . Do not wear the same gown and gloves for the care of more than one person.Review of R18's EMR revealed the following physician order: Follow EBP guidelines during wound and foley care as well as during high contacts resident care activities (dressing, showering, transferring, changing linens or briefs) . Active 8/21/2025.Review of the facility policy titled, Enhanced Barrier Precautions, dated 5/07/2025, revealed the following: EBP should be used during contact with all residents who have any of the following . Wound(s) regardless of MDRO [multidrug-resistant organism] colonization status. Indwelling medical devices (e.g., central line, IUC [indwelling urinary catheter], feeding tube, tracheostomy, ventilator) . Enhanced Barrier Precautions includes the following practices: . Hand hygiene . Gloves . Gowns .

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility failed to maintain an effective abuse training program for two out of five staff members reviewed for new hires and annual training. Findings include:A review of staff education records and competencies on 9/4/25 revealed the following staff members had not completed the required abuse, neglect and exploitation training:Certified Nurse Aide (CNA) E - Hired on 7/16/25 and had not completed abuse training prior to start date.CNA F - Hired on 8/21/23 with last completed abuse training on 6/26/24.An interview conducted with the Director of Nursing (DON) on 9/4/25 at approximately 10:30 a.m. confirmed staff abuse training had not been completed per the facilities policy.Review of the facility's Abuse, Neglect, Misappropriation or Exploitation Policy/Procedure, undated, read, in part, .employees will receive training regarding abuse, neglect, exploitation, misappropriation of property, or mistreatment during new employee orientation and on an annual basis.