STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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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 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** Based on observation, interview and record review, the facility failed to 1.) Provide Personal Protective Equipment (PPE) in the soiled utility rooms and resident rooms that were on transmission-based precautions (TBP) and enhanced barrier precautions (EBP) for Resident #67, #3, #29, and #53; 2.) [NAME] (put on) PPE when providing care for residents in EBP for Resident #5, #67, and #74; 3.) Clean and properly store nebulizer equipment for Resident #10; 4.) Ensure an active Water Management Plan specifically tailored to the facility. These deficient practices resulted in the potential for cross contamination and the spread of disease to all residents that reside in the facility. Findings include: Resident #10: During an observation on 12/01/2025 at 9:58 AM, Resident #10's nebulizer (medical device that converts liquid medication into a mist to deliver the medication) mask was on her bedside table in direct contact with the table and with no protective barrier. The nebulizer mask had white residue, streaks, and flakes on the inside of the mask. During an observation on 12/01/2025 at 1:25 PM, Resident #10's nebulizer mask remained in the same spot as earlier, 12/01/2025 at 9:58 AM. The nebulizer mask had white residue, streaks, and flakes on the inside of the mask and no protective barrier. During an observation on 12/01/2025 at 3:20 PM, Resident #10's nebulizer mask remained in the same spot as earlier, 12/01/2025 at 9:58 AM and 12/01/2025 at 1:25 PM. The nebulizer mask had white residue, streaks, and flakes on the inside of the mask and no protective barrier. During an observation on 12/02/2025 at 8:21 AM, Resident #10's nebulizer mask and other plastic pieces were sitting on paper towel next to the sink near the entry door of Resident #10's room. The nebulizer mask had white residue, streaks, and flakes on the inside of the mask. The soiled area was most prominent around the inner edges of the nebulizer mask. During an observation on 12/2/25 at 12:26 PM, Resident #10's nebulizer mask and plastic accessory parts were sitting on a paper towel directly next to the sink in her room, same as earlier, 12/02/2025 at 8:21 AM. The nebulizer mask had white residue, streaks, and flakes on the inside of the mask. There was a white cloth towel placed to the left of the sink and was partially covering the lower end of the mask in direct contact. During an observation on 12/03/2025 at 8:21 AM, Resident #10's nebulizer mask and plastic accessory parts remained on a paper towel directly next to the sink in her room. The nebulizer mask had white residue, streaks, and flakes on the inside of the mask. Review of Resident #10's physician order for ipratropium-albuterol (medication to make it easier to (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	breathe), start date 9/23/25, indicated it was to be given twice a day by way of inhalation with use of a nebulizer (medical device that converts liquid medication into a mist to deliver the medication) for shortness of breath/wheezing. Review of Resident #10's medication administration history, dated 12/1/25-12/3/25, noted ipratropium-albuterol solution for nebulization order was provided twice a day on 12/1/25 and 12/2/25. Review of the facility's Respiratory Equipment policy, Review Date: 12/16/24, stated, To provide infection control guidelines to help prevent infections associated with respiratory therapy equipment and to prevent transmission of infections to residents and staff .Medications Nebulizers .After completion of therapy .Wipe mouthpiece (facility's nebulizer for Resident #10 used a mask) with damp paper towel or gauze sponge .Store circuit (disposable or reusable accessory portion of a nebulization system; includes mask) in plastic bag, marked with date and resident's name, between uses . Residents #3, #53, and #29: During an observation on 12/02/2025 at 9:55 AM, outside Resident #3 and #53's room a sign was posted to the left of the entry door. This sign was from the Centers for Disease and Control Prevention, undated, and stated, Droplet Precautions Everyone Must:.Make sure their eyes, nose and mouth are fully covered before room entry and showed two examples of appropriate eye protection (full face shield and appropriate goggles). Outside the room was also a bin which contained personal protective equipment (PPE) to be worn for entry into the room. The bin contained disposable gloves, sanitizer wipes, surgical masks, and gowns. There was no eye protection PPE available. During an observation on 12/02/2025 at 9:59 AM, Registered Nurse (RN) L entered Resident #3 and #53's room and interacted with Resident #3. RN L was only wearing personal eyeglasses (not personal protective equipment for eye protection) and a surgical mask. During an interview on 12/02/2025 at 10:02 AM, she reported Resident #53 had influenza A (the flu; a viral infection) and was the reason for droplet precautions. RN L confirmed there was no eye protection in the PPE bin or available outside the room for Resident #3 and #53's room which was under droplet precautions. RN L also confirmed Resident #29 had influenza A down the hall, was on droplet precautions, and the PPE bin outside that room also didn't have eye protection available. When asked where eye protection was RN L confirmed there was none on the unit and left the unit/hall looking for some. During an observation on 12/02/2025 at 9:57 AM, Resident #29's room had the same droplet precaution signage as Resident #3 and #53's room did. The bin of PPE outside of Resident #29's room had gloves, gowns, and surgical mask. There was no eye protection PPE available. Review of the facility's Guidelines for Droplet Precautions policy, revised 3/19/20, stated, Examples of infections requiring droplet Precautions include but are not limited to: .Influenza .Isolation Signs .Place a sign on the door indicating the description of the type of precautions . Resident #5 Review of an admission Record revealed Resident #5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes and venous insufficiency (condition where valves in the leg veins become damaged, causing blood to pool in the legs instead of flowing efficiently to the heart). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #5's Orders revealed, Staff to use enhanced barrier precautions (EBP), wearing a gown and gloves at minimum during high-contact care activities. Special instructions: Venous ulcer to left shin and left heel. Start date: 10/6/25. In an observation on 12/01/2025 at 11:40 AM, Resident #5's room door had a sign indicating that Resident #5 was on EBP, and that staff were required to don a gown and gloves when providing high contact care. It was also noted that there was a cart outside of Resident #5's room with PPE in it for staff to don prior to entering Resident #5's room. In an observation on 12/01/2025 at 11:43 AM, Certified Nursing Assistant (CNA) E entered into Resident #5's room and applied gloves and made Resident #5's bed. It was noted that CNA E was not wearing a gown. In an observation on 12/02/2025 at 3:05 PM, Licensed Practical Nurse (LPN) D entered Resident #5's room and donned gloves. LPN E then removed Resident #5's socks on both of his feet and began cleaning Resident #5's right and left toes with wound cleanser. After cleaning Resident #5's toes with wound cleanser, LPN D dried Resident #5's right and left toes and applied skin prep (protective liquid applied to the skin to form a barrier, helping to prepare the skin for wound care, adhesive dressings, and other medical applications). It was noted that LPN D was not wearing a gown when providing wound care for Resident #5. In an interview on 12/02/25 at 3:25 PM, LPN D reported that she did not think Resident #5 was on EBP, and she did not know of any reason that Resident #5 would need to be on EBP. When this writer queried about Resident #5's wounds, and if that would be considered a reason for EBP, LPN D was unable to confirm if wounds would be an indication for a resident to be on EBP. Resident #74 Review of an admission Record revealed Resident # 74 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertension (high blood pressure) and congestive heart failure (condition that happens when your heart can't pump blood well enough to give your body a normal supply). Review of Resident #74's Orders revealed, Staff to use EBP, wearing a gown and gloves at minimum during a high-contact care activities. Start date: 12/1/25. In an observation on 12/01/2025 at 11:20 AM, Resident #74's room door had a sign indicating that Resident #74 was on EBP, and that staff were required to don a gown and gloves when providing high contact care. It was also noted that there was a cart outside of Resident #74's room with PPE in it for staff to don prior to entering Resident #74's room. In an observation on 12/01/2025 at 11:27 AM, CNA E entered Resident #74's room without donning a gown or gloves and assisted Resident #74 to the restroom. Resident # 67 Review of an admission Record revealed Resident #67 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes and Infection and inflammatory reaction due to indwelling urethral catheter (is a flexible tube inserted into the bladder to continuously (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	drain urine). Review of Resident #67's Orders revealed, Staff to use enhanced barrier precautions (EBP), wearing a gown and gloves at minimum during high-contact care activities. Start date: 12/1/25. In an observation on 12/03/2025 at 8:25 AM, Resident #67's room door had a sign indicating that Resident #67 was on EBP, and that staff were required to don a gown and gloves when providing high contact care. It was also noted that there was not a cart of PPE next to Resident #67's door. In an observation on 12/03/2025 at 8:37 AM, Resident #67 was in his restroom yelling out for help. MDS RN (Registered Nurse) (MDS-RN) BB entered Resident #67's room to assist him in the restroom. It was noted that MDS-RN BB did not don a gown or gloves prior to entering Resident #67's room to assist him in the restroom. At 12/03/2025 at 8:42 AM, CNA KK and CC entered Resident #67's room to assist MDS-RN BB in caring for Resident #67. It was noted that CNA KK and CC did not don gown and gloves prior to entering Resident #67's room. In an interview on12/03/2025 at 8:51 AM, CNA CC confirmed that she and CNA KK did not don a gown prior to providing care with Resident #67, because she did not think that they needed to don a gown when providing care for Resident #67 unless they were emptying his catheter. In an interview on12/03/2025 at 9:00 AM, MDS-RN BB confirmed that Resident #67 did not have cart with PPE for staff to don prior to entering Resident #67's room. MD-RN BB reported that Resident #67 was on EBP, and that she and CNA CC and KK had overlooked this when providing care to Resident #67, so they had not donned PPE appropriately prior to providing care to Resident #67. Review of the facility's Enhanced Barrier Precautions policy last revised 4/2/24 revealed, Overview: Guidance for enhanced barrier precautions (EBP) to decrease risk of becoming colonized and developing infections with multidrug-resistant organism (MDRO) status. EBP does not replace existing guidance regarding the use of Contact precautions for other pathogens (ie: Cdiff, scabies, norovirus, ect). SOP (Standard operating procedure) Details: Enhanced Barrier Precautions (EBP) will be in place during high-care contact activities for residents with the following conditions: A. Residents an increased risk of MDRO acquisition which include I. All residents with chronic wounds, including but not limited to, pressure ulcers, diabetic foot ulcers. unhealed surgical wounds, and venous stasis ulcers. II. All residents with indwelling medical devices include but not limited to: catheters, central lines, feeding tubes, tracheostomy tubes . B. Residents known to be infected or colonized with MDRO. 2. Personal Protective Equipment should be used even if blood and body fluid is not anticipated. A. At minimum, Staff shall wear gloves and gowns during high-contact care activities. May include face protection if splashes or sprays are anticipated during care. 3. High-contact care activities include but are not limited to: morning and evening ADL (activities of daily living) care, toileting, and showers . On 12/1/25 at 11:19 AM, observation of the 500 Hall Soiled Utility room found an uncovered hopper (used for cleaning debris from soiled linens) with only one box of gloves, and no other available personal protective equipment (such as a gown and facemask) for easy use by staff. On 12/1/25 at 11:27 AM, observation of the 300 Hall Soiled Utility room found an uncovered hopper, an empty box of gloves on the wall, and no available gown or facemask for use. On 12/1/25 at 11:32 AM, observation of the 200 Hall Soiled Utility room found an uncovered hopper, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	no gloves, no gown, and no facemask for use. On 12/1/25 at 11:35 AM, observation of the 400 Hall Soiled Utility room found an uncovered hopper, no gloves, no gown, and no facemask for use. On 12/1/25 at 12:50 PM, an interview with Environmental Services Associate V found that staff on the floor do use the hoppers when they are needed. On 12/1/25 at 1:15 PM, the facilities Water Management Plan (WMP) binder was provided by the Nursing Home Administrator. On 12/1/25 at 1:20 PM, a review of the first document in the binder entitled Legionella Water Management Plan, not dated, found that it was not tailored to this facility, but rather referenced a sister facility, including the name, address and facility layout of this other location. Further review of the document found no documentation that an annual review had been performed. Under the heading Control Measures and Monitoring, the document states that, Monthly the Director of Plant Services test the cold and hot water for total hardness, total chlorine, free chlorine, total alkalinity, and pH using test strips. No results, logs, or documentation of control limits were found.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain complete and accurate medical records for 1 resident (Resident #9) of 24 sampled residents reviewed for complete and accurate medical records, resulting in inaccurate documentation of advance directives (personal choices of medical treatment options) and the potential for Resident 9's wishes to not be honored appropriately.Findings include:Review of a Face Sheet revealed Resident #9 was a male, with pertinent diagnoses which included: Alzheimer's disease, unspecified (a form of dementia) and unspecified dementia, unspecified severity, with other behavioral disturbance.Review of Resident #9's General Procedures DO-NOT-RESUSCITATE document revealed, .B. I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant. signed by Family Member (FM) NN on [DATE] and Medical Doctor (MD) OO on [DATE].Review of Resident #9's Electronic Medical Record resident identifier banner (the banner at the top of the screen that lists resident name, age, and other pertinent information) revealed resident was DNR (do not resuscitate).Review of a Physician's Order for Resident #9 revealed, General [DATE] - Open Ended Code Status: FULL CODE CPR (cardiopulmonary resuscitation) MD OOIn an interview on [DATE] at 10:54 AM, Director of Nursing (DON) B reviewed Resident #9's electronic medical record with this surveyor. DON B reported Resident #9's banner indicated that Resident #9 was a DNR. DON B reported Resident #9's DNR paperwork indicated that Resident #9 was a DNR. DON B reported Resident #9's physician order was for Full Code CPR. DON B reported Resident #9 had just changed his code status the week before and the physician order did not get changed but should have. DON B reported it was her expectation that the paperwork, the banner, and the physician's order match.In an interview on [DATE] 9:32 AM, Nursing Home Administrator (NHA) A reported it was her expectation that all code status paperwork matched because if not, resident advance directive wishes may not be followed.