STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235646	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caretel Inns of Linden	202 South Bridge Street Linden, MI 48451

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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** Based on observation, interview, and record review, the facility failed to 1) 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 water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the residents in the facility; 2) Complete routine resident and staff Infection Surveillance, including audits/environmental rounds, analyze data for trends and report findings and 3) Ensure the appropriate use of Personal Protective equipment, per Standards of Practice, which could lead to an outbreak of infectious organisms, and illness. Facility Infection Control On 9/09/2025 at 10:48 AM during an interview with IP/Infection Preventionist “H”, she said she was new to the role. She started in December 2024 and completed the CDC/Center for Disease Control and Preventions Certificate training course for Long Term Care/LTC on 4/6/2025. When asked to review the Infection Surveillance data for the prior year, September 2024 through September 2025, The IP “H” said she began collecting Infection Surveillance in April 2025, and surveillance prior to that was completed by someone else. During the interview with IP “H” on 9/9/2025 at 10:48 AM, it was noted that the Infection Surveillance for July 2025 with line listings, analysis and reporting, (to track resident infections, review data for trends and report findings to aid in preventing the development and spread of infection) was completed, but there was no additional monthly Infection Surveillance for the year with line listings, analysis and reporting per the following: October 2024, November 2024 and December 2024 was identified to have some Infection surveillance line listings, but no summary/analysis. January 2025, February 2025, March 2025, April 2025, May 2025, June 2025, did not have line listings, analysis or reports. Some months had individual Infection worksheets for some residents and some months had nothing. August 2025, no September 2025 surveillance data, no line listing, some resident surveillance, no summary report, no antibiotic stewardship reporting for months without Infection surveillance. There was limited staff surveillance for infections, beginning May 2025. On 9/9/2025 at 11:30 AM, the Infection Preventionist “H” was interviewed about the (continued on next page)

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	months with no Infection Surveillance data over the past year and she said that is how it was when she started in the role, and she was trying to learn, and July 2025 was the month she had the most up to date information. She said she was working on audits, but the audits were not in writing. She said she began Hand hygiene, PPE use, pericare education in August 2025. She said she began attending the QAPI/Quality Assurance Process Improvement meetings in June 2025 and started reporting at QAPI. During the interview with the IP “H” on 9/9/2025 at 11:45 AM, identified issues with environmental cleanliness during the survey was discussed, including cleanliness issues from a lack of cleaning found in resident rooms and in the building. The IP “H” said she wasn't performing environmental rounds but planned to start. She said she was not aware of the residents', families and visitors' complaints of uncleanliness in the building, including the 100 Hallway. Also, during the interview, IP “H” was asked what she had identified as an issue based on her Infection Surveillance, and she said “UTI's” (urinary tract infections). She said she had 2 residents with the same Multi-drug-Resistant Organism/MDRO of ESBL E.coli. Both residents resided on the same hall/100 and both residents had concerns with their bathroom and rooms not being routinely cleaned or disinfected. The IP “H” referenced Resident #22 as having ongoing UTI's. When asked about Infection Surveillance, she said she only had the July 2025 information. IP “H” also said Resident #3 was identified to have the ESBL E. coli in her urine identified in July 2025, there had not been monthly Infection Surveillance prior to this. A review of the July 2025 Infection Surveillance data revealed Resident #67 was transferred to the hospital on 6/30/2025 and readmitted on [DATE] with diagnoses UTI (7/1/2025) and sepsis (systemic infection response). Resident #67 was initially admitted to the facility on [DATE] prior to the discharge to the hospital with a change of condition. IP “H” confirmed the facility had not been continuously monitoring Infection Surveillance during Resident #67's stay at the facility. Resident #67 also resided on the 100 hall. A review of the facility policy titled, “Infection Surveillance,” dated 10/2014 and reviewed 12/21 provided, “Guideline: Surveillance of infection swill be completed to calculate baseline rates, detect outbreaks, track progress and determine trend to assist in preventing the development or spread of infections. The goal is to minimize the number of infections and to identify behaviors or environmental factors that may warrant further evaluation… Infection prevention will review the Infection Surveillance data to identify trends and outbreaks at least monthly. IP will conduct surveillance at least once per week. Monthly environmental rounds and review of physician orders for antibiotics and laboratory results should be included…” On 09/03/2025 at 7:11AM during the initial kitchen tour, observed dead end plumbing near the coffee machine. The dead-end plumbing was a water line with an attached backflow preventer for beverage machines. On 09/03/2025 at 8:36 AM record review of the facility's Water Management Plan is missing the following: a description of the building water system with both a text and flow diagram. The last Legionella meeting inside the Water Management Plan binder is dated 2/21/18. On 09/03/2025 at 8:51AM-9:25AM conducted interview with the Director of Maintenance F on chlorine residual testing, and he stated that chlorine residual is completed on site on a weekly basis. On 09/03/2025 at 8:51AM-9:25AM record review of the chlorine residual and water temperature log (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	provided by the Maintenance Director F, there are several empty lines in the chlorine residual and the water temperature columns for Van Gogh room [ROOM NUMBER], [NAME] room [ROOM NUMBER], and [NAME] room [ROOM NUMBER]. Several of the chlorine residual are recorded to be very high at 116.2 111.2 and 77ppm. Conducted interview with the Maintenance Director F on the extremely high chlorine residual results and he stated that the water temperatures and chlorine residual must have been switched around. According to the Centers for Disease Control and Prevention, Controlling Legionella in the Potable Water System dated January 3rd, 2025, Ensure disinfectant residual is detectable throughout the potable water system. and Eliminate dead legs, which are sections of no- or low-water flow. Resident #70 R70 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dysphagia, heart failure, cerebral infarction and hemiplegia and hemiparesis. On 09/05/2025 at 9:56AM, it was observed that R70 is in enhanced barrier precautions related to their enteral tube. Licensed Practical Nurse (LPN) A was performing medication administration for R70. LPN A was observed not applying the proper personal protective equipment (PPE) for the clinical situation. LPN A applied gloves only. LPN A performed medication administration for R70 and exited the room upon completion. Upon exiting the room LPN A was asked if they should have applied PPE prior to administering medication for this resident? LPN A stated, yes, I should have applied a gown in addition to my gloves, prior to administration of the medication. LPN A' was asked why they didn't apply the proper PPE. LPN A stated, I just forgot, it was an oversight. On 09/05/2025 at 10:30AM, record review revealed a physician's order that read, Maintain enhanced barrier precautions to prevent infections r/t enteral feeding tube/history of klebsiella pneumoniae and ecoli, dated 09/02/2025.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review, the facility failed to ensure that the appropriate backflow prevention was installed on cross connections. This deficient practice increases the likelihood of contamination of the water supply due to a backflow event, potentially affecting all residents, staff, and visitors who consume water at the facility.Findings include: On 09/03/2025 at approximately 7:25 AM, observed a hose attached to a spigot without a hose bib vacuum breaker located in the [NAME] sub kitchen. On 09/03/2025 at approximately 9:15 AM, observed a chemical dispenser attached to a utility sink downstream of an atmospheric vacuum breaker (AVB) without a wasting tee, located in the janitor's closet in 300, 200, and 100 hallways. 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).According to the 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Numbers 2586675 and 2594091.Based on observation, interview, and record review the facility failed to provide a clean, comfortable and home like environment to ensure that resident rooms, bathrooms and common areas were clean, for residents on the 100 hall and for a Confidential Group of Residents on the 100, 200 and 300 halls, resulting in an unclean physical environment, resident dissatisfaction and complaints regarding the lack of cleanliness, and Infection Control practices. Environment During a tour of the building on 9/3/2025 at 7:45 AM, there were multiple observations of unclean resident rooms on the 100 hall. Several rooms were noted to have a strong, foul odor including room [ROOM NUMBER] and #114. Many rooms were cluttered with items, including items on the floor, windowsills and other surfaces. Several Resident rooms were noted to have wastebaskets overflowing onto the floor. Resident bathrooms were noted to have large rust stains coated in the sink and toilets. Some of the toilets were also soiled with brown/gray stains and feces. Several resident rooms had uncovered toothbrushes stored on the sink and in some of the rooms 2 residents shared the same bathroom. The following resident rooms had cleanliness issues: Rooms: 101- rusty sink and toilet; 104- urine smell in room, soiled clothes on the floor, bathroom soiled rust coated sink and toilet, toothbrush bare on the sink counter; room [ROOM NUMBER]- cluttered and soiled surfaces in room and bathroom, wastebasket in bathroom overflowing; room [ROOM NUMBER]- bathroom with soiled toilet and sink, wastebasket overflowing onto floor; room [ROOM NUMBER]- soiled toilet and sink; room [ROOM NUMBER]- bathroom toilet and sink soiled. On 9/03/2025 at 9:31 AM, during an interview with a Confidential Resident, they said their room was not cleaned, very often, It's pretty good except for the commode, they don't clean it. On 9/03/2025 at 9:48 AM, a Confidential Resident was interviewed and stated, They cleaned last Wednesday or Thursday, almost a week ago. They are supposed to do it twice a week, but recently it was 2 weeks before it was cleaned. The resident said their toilet was very soiled, trash overflowing, the sink was stained dark orange from rust. Another Confidential Resident said their room was last cleaned over one week ago on Monday (in August). On 9/3/2025 at 10:14 AM, Housekeeper I and Housekeeping Supervisor F were interviewed about cleaning the residents' rooms. Housekeeper I stated, We try to take care of it the best we can. Asked about the rust soiled sinks and toilets. Housekeeper I showed the product used to clean the bathroom and it said Disinfectant, asked if it was also able to remove the stains because the bathrooms were very soiled. Housekeeping Supervisor F said he would check into it. He also said the facility had hired a 3rd housekeeper who was in day one of orientation on 9/3/2025. He said there was a total of 3 housekeepers, We do the best we can. Reviewed the observations of waste baskets not emptied, and multiple resident complaints of trash overflowing on the floors in their rooms and no trash bag in the garbage can. Also on 9/3/2025 at 8:15 AM, soiled gloves with a pink stain were observed sitting on a counter in the small dining/day room and remained for several hours; toothbrushes noted in multiple rooms laying on the bare sink surfaces uncovered and several rooms with foul odors including a strong urine smell with soiled toilet bowls. Housekeeping Supervisor F said they were going to try to fix the issues. Copies of the Housekeeping cleaning schedule was requested. On 9/4/2025 at 8:45 AM, during an interview with Confidential Person J, she said she had visited the facility to see a family member on multiple occasions and the resident's room did not appear to be cleaned very often. She said the windowsills had someone's food on them, the floors were not cleaned, and the bathroom was soiled. She said she had spoken to someone about it and the uncleanliness did not change. A review of the facility cleaning schedule titled, Housekeeping Hall schedule undated had a list for Monday-Sunday. On it there was listed halls 100, 200, 300, 500 and 700. The facility only had halls 100, 200 and 300; 500, 700 and 800 were in the Assisted Living. Per the cleaning schedule Hall 100 was to be cleaned on Monday, Wednesday, Friday and Sunday. Hall 200 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was to be cleaned on Monday, Tuesday, Thursday, Friday, and Saturday. Hall 300 was to be cleaned every day. In addition, the common areas were cleaned Monday, Wednesday, Friday and Sunday. The residents' rooms were not cleaned daily and per the residents they were not always cleaned on their scheduled days. The cleaning schedule also said the housekeepers would handle the laundry on the weekends between room cleaning. There was also a list of items to be cleaned for the 200 hall (that was to be cleaned almost daily), but there was no list for the 100 Hall.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 2586675. Based on observation, interview and record review the facility failed to review and revise Care Plans to ensure a resident-centered comprehensive care plan for four residents (#21, #22, #60 and #67) of 40 residents reviewed, resulting in the residents (#21, #22, #60 and #67) lacking a Care Plan with resident specific interventions. Resident #21 Accidents Falls A record review of the Face sheet and electronic medical record indicated Resident #21 was admitted to the facility on [DATE] with diagnoses Dementia mood disturbance with anxiety, and weakness. Per the progress notes, Resident #21 was receiving Hospice services.On 9/03/2025 at 10:03 AM, Resident #21 was observed in the hallway with her legs hanging over the side of a broda chair. She was leaning forward and trying to move the chair. Nurse Aide M approached the resident and was asked if the resident was trying to get up out of the chair and she stated, Yes. She said the resident repeatedly tried to stand and they would try to lay her down and she would not stay in bed. A record review of the progress notes identified the resident had 2 recent falls on 8/29/2025 and 8/23/2025. Further review of the progress notes identified the following: 8/22/2025 at 22:58 PM, a Behavior note Resident is restless, unable to relax, sit still or sleep. Keeps trying to walk. 8/23/2025 at 12:20 PM, a Health status/Progress note, Resident was observed on floor of her bathroom on her left lateral thigh and hip, left hand was on the floor. She yelled help . It appears she was attempting to pull her pants up. Frequently incontinent, although will go on toilet if prompted. 8/25/2025 at 5:33 PM, a Behavior note, Resident found out of her w/c (wheelchair) without assistance @ around 1030. Was assisted back into her chair by writer. Resident also had to be redirected multiple times during shift to not get out of w/c without assistance (she was stopped multiple times by various staff as she was sliding forward in w/c seat. 8/29/2025 at 3:59 PM, a Health Status/progress note, Resident observed on floor in bathroom crying out for help. Resident was in bed prior to incident. Resident self-transferring without assistance. A review of the Incident and Accident Reports for Resident #21 revealed the times of her falls were: 8/23/2025 at 11:00 AM and 8/29/2025 at 9:45 AM. A review of the Care Plans for Resident #21 identified the following: The resident has a behavior problem r/t (related to) calling out at night, attempting to self-transfer, yelling at staff, resistive to care at times, date created and initiated 7/31/2025 and revised 8/26/2025 with one Intervention dated 7/31/2025, Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her (did not specify this was a her) as passing by. There were no additional interventions related to the resident wanting to stand, walk and go into the bathroom. Potential for falls, Resident at risk for injury from falls. Weakness, Unsteady Gait, Poor safety awareness/impulsiveness, date created, initiated and revised 7/29/2025 with new Interventions: Hospice to complete med review to address increased restlessness, date created and initiated 8/26/2025 and Offer toileting after breakfast, date created and initiated 9/2/2025. The ADL, Care Plan said, Toileting or check and change every 2 hours and (as needed). The progress notes indicated Resident #21 was attempting to toilet herself on several occasions. There was no specific plan for toileting until 9/2/2025 and the resident had fallen twice. A review of the physician orders indicated Resident #21 began receiving Ativan 0.5 mg tab two times a day as needed on 8/12/2025 for anxiety. This was not mentioned on the Fall Care Plan, Behavior Care Plan or other Care Plan. The resident continued receiving the medication through 8/28/2025. On 8/27/2025 the Controlled Substance Proof of Use document indicated the resident received the medication 3 times in the same day: 7:00 AM, 3:00 PM and 9:00 PM. This was more than was ordered. On 9/5/2025 at 9:20 AM Resident #21 was observed in hallway in the Broda chair, smiling, alert. The CNA said the resident was doing good today, had a bad day yesterday, yelling, trying to stand from chair, would not lay down in bed. Resident #22 Urinary Catheter or UTI A record review of the Face sheet and electronic medical record/emr indicated Resident #22 was admitted to the facility on (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] and readmitted on [DATE] with diagnoses: Multiple sclerosis, gait abnormality/stiffness, neuromuscular bladder dysfunction, history of urinary tract infections, glaucoma, and anxiety. The resident had a Brief Interview for Mental Status/BIMS score of 15/15 indicating full cognitive abilities. The resident needed some assistance with care. On 9/03/2025 at 10:20 AM, Resident #22 was observed lying in bed, she said she was taking an antibiotic for a urinary tract infection/UTI. She said she used a straight catheter by herself, as she could not urinate otherwise. A review of the physician orders revealed the following: Patient completes self-catheterization, Skilled nurse to educate and monitor patient ability and hygienic efforts, every shift, dated 8/18/2025. Skilled nurse to encourage and offer patient iodine swabs or antiseptic wipes for self-catheterization, document compliance and (acceptance), every shift, dated 8/18/2025. Maintain enhanced barrier precautions to prevent infections r/t history CDC targeted MDRO (multi-drug-resistant organism) ESBL (extended spectrum beta-lactamase producing)/E.coli, every shift, dated 8/19/2025.In addition, the physician orders identified the resident was currently being treated for a urinary tract infection/UTI and had a history of repeated UTI's. A review of the Care Plans for Resident #22 identified the following: I have potential for infection, complications r/t my dx (diagnosis) of urinary retention, Neurogenic bladder, I require SC (straight catheterization). I have MS, date created and initiated 11/28/2018 and revised 5/15/2019 with Interventions including: Intermittent catheterizations completed by guest, dated initiated and created 11/28/2018 and revised 6/18/2020; Remind resident to clean area prior to catheterization, date created and initiated 3/2/2023. Resident completes self-catheterization r/t neurogenic bladder, date created and initiated 7/14/2025 and revised 9/4/2025 with Interventions all dated 9/4/2025. I require enhanced barrier precautions r/t CDC targeted MDRO ESBL E.coli and Self catheterization, date created and initiated 5/31/2024 and revised 8/19/2025. Resident has: UTI/E.coli requiring Contact Precautions until antibiotics are completed on 9/11/25; 24 hours after d/c (discontinue) isolation, Resume enhanced barrier precautions after Contact is completed, date created and initiated 8/18/2025 and revised 9/9/2025 with no interventions. (Resident #22) is prescribed antibiotics for a UTI, dated created and initiated 6/18/2024 and revised 9/2/2025. The Care Plans did not mention the size, or any specifics of the Straight catheter Resident #22 was to use. There was no mention of how many times the catheter could be used to prevent the spread of infection, as the resident had ongoing UTI's with Multi-drug-resistant organisms. There was mention of cleansing the area but did not mention exactly what area. There was no mention of hand hygiene to prevent the spread of infection for Resident #22. The Care Plans did not provide resident specific interventions to aid in preventing further UTI's. Resident #60 Accidents Falls A record review of the Face sheet and electronic medical record/emr revealed Resident #60 was admitted to the facility on [DATE] with diagnoses: Alzheimer's Dementia, anxiety, hypothyroidism, chronic kidney disease, and heart disease. The resident had severe cognitive loss and needed assistance with all care. A record review of the progress notes indicated Resident #60 had a fall beside her bed on 8/9/2025 at approximately 2:05 AM. The resident sustained an abrasion on her left elbow. A review of an Incident and Accident Report dated 6/22/2025 at 11:45 PM the resident was observed on the floor by her bed. She sustained redness to her left forehead, and right knee and a skin tear on her left hand. A review of the Care Plans for Resident #60 identified the following: At risk for falls r/t confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of safety needs, history of falls, cognitively impaired, medication side effects, pain, date created and initiated 4/14/2022 and revised 5/17/2024. The Care Plan was last updated 6/23/2025 Ensure resident has stuffed comfort animal within reach to prevent restlessness. The Care Plans were not reviewed or revised after the resident fell on 8/9/2025. Potential for falls, Resident at risk for injury from falls, dated created 12/21/2022, and initiated and updated 6/11/2024 with Interventions last updated 6/11/2024. Resident #67 Pressure Ulcer/Injury A record review of the Face sheet, Minimum Data Set/MDS assessment and electronic medical record/emr indicated Resident #67 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Diabetes, history of a stroke, dementia, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pulmonary embolism, history of deep vein thrombosis, Parkinson's, heart failure, hypertension, Gout, depression, restless leg syndrome and pneumonia. The MDS assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status/BIMS score of 9/15 indicating moderate cognitive decline. The resident also needed assistance with care. The resident discharged to the hospital on 8/8/2025 and did not return to the facility.The MDS section M for Skin Conditions dated 7/13/2025 revealed the resident did not have a pressure ulcer: Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device- No, was checked. The question Is this resident at risk of developing pressure ulcers/injuries? was checked Yes.On 9/09/2025 at 8:45 AM, during an interview with Confidential Person J she said Resident #67 developed 3 pressure ulcers at the facility: 1 left ear, sacrum/coccyx and left elbow. A review of the progress notes identified the following: 8/7/2025 at 3:27 PM, a Health status/progress note Left lateral elbow open area, 2cm x 1.5 cm, round/irregular shape, full thickness, with 100% firmly adherent yellow slough (dead tissue) covering wound bed, wound bed not observed. Moderate serous drainage. x2 open areas on sacrum observed, along spine: superior: 1.8cm x 1cm, thickness at least 0.1 cm, full thickness open area, oval configuration, 100% firm adherent yellow slough attached to wound bed. Inferior: 1.6cm x 0.8cm, oval configuration, thickness at least 0.1cm, full thickness open area with wound bed 50% non-granulated/adherent yellow slough. A note dated 8/3/2025 identified the resident had an open area on the left ear. A review of the Care Plans for Resident #67 identified the following: Skin: Potential for alteration of skin integrity, dated created and initiated 10/10/2024 with all interventions dated 10/10/2024, including: Check skin daily, Pressure redistribution mattress, Remind/Assist resident to reposition frequently. ADL (activities of daily living): Self-care deficit, require assist with ADL's r/t (related to) limited mobility, debility, and impaired balance, date created and initiated 10/10/2024 and revised 1/7/2025 with Interventions including: Bed Mobility: I need extensive assist of 2 to help me, dated initiated and created 10/10/2024. Potential/At Risk for alteration in skin integrity due to risk factors associated with Cognitive impairment, Immobility, date initiated 8/8/2025. The day of discharge. Alteration in skin integrity-Resident has Pressure Injury. Site: Sacrum/Left elbow, Factor that may inhibit wound healing: Immobility, Incontinence, dated created, initiated and revised 8/8/2025. The date 8/8/2025 was the day the resident was transferred to the hospital and did not return. There was no mention of the area on the resident's left ear. Per a Dietary review dated 4/23/2025 at 2:32 PM, Resident #67 had Weight loss of 10% x 5 weeks & x 5 months. A review of the Weight Summary indicated the resident had a gradual weight loss from 4/22/2025 to 8/1/2025 (10 lbs.), but had lost 70 lbs. from 10/11/2025 to 8/1/2025. The resident returned from the hospital on 7/10/2025 with a feeding tube. The resident's Care Plans were not updated to note her increased risk of skin breakdown, with her weight loss and declining condition.

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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. Based on observation and interview, the facility failed to ensure that medications and supplements were labeled, stored and disposed of properly, resulting in expired supplements in the medication room, expired over the counter medication and loose and unlabeled medications in the medication carts.Findings include:On 09/05/2025 at 11:15AM, observation of the main hall medication storage room revealed the following expired item: - Three expired bottles of Jevity 1.5, the information on the bottle read, use before 9/1/25. These findings were verified with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) B. The DON disposed of the expired items. On 09/05/2025 at 12:23PM, observation of the 200 hall medication cart revealed the following expired item:- One bottle of Vitamin B-12, expired on 08/2025. This finding was verified with LPN C, LPN C stated they would dispose of the expired over the counter medication immediately. On 09/05/2025 at 12:30PM, observation of the 100 Hall Med Cart revealed the following findings:- Two medications (Hydroxyzine and Sertraline) sitting in the top drawer, they had no resident name on them.- One loose pill.These finding were verified with Registered Nurse (RN) C. RN C was asked about the unlabeled medications located in the cart medication cart. RN C stated, they were medications that were left over from last night. They belong to R21, but we no longer have a need for them since the medications came in from pharmacy. RN B was asked about the loose pill that was in the cart. RN B stated, That pill is a baby aspirin, I usually keep this cart pretty clean, I am not sure how it got there. RN B was observed disposing of the medications immediately. Review of the policy titled, Medication Storage in the Facility, revealed: Policy:Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures:C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label.H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedure for medication disposal and reordered from the pharmacy if a current order exists. Expiration Dating:G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining. The medication will be destroyed in the usual manner.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly dispose of waste and maintain dumpster area to mitigate the presence of insects and rodents, potentially affecting all residents, staff, and visitors in the facility.Findings include:On 09/03/2025 at approximately 8:51 AM -9:25 AM, during the environmental tour with the Maintenance Director F, observed a McDonald's wrapper, multiple dirty gloves, the cement surrounding the dumpster visibly soiled with dark waste, and the lid was open on one of two dumpsters. On 09/03/2025 at approximately 8:51-9:25AM conducted interview with Maintenance Director F on the cleaning schedule for the dumpsters, and he stated that because of the holiday weekend, they've been falling behind, but the dumpster area is usually cleaned every other day. According to the 2022 Food Code, 5-501.115 Maintaining Refuse Areas and Enclosures A storage area and enclosure for refuse, recyclables, or returnables shall be maintained free of unnecessary items.

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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 ensure residents were treated in a respectful and dignified manner for 2 Residents (#22 and #59) from a facility census of 52 residents, resulting in missing items not being replaced in a timely manner for Resident #22 and some confidential group of residents were unable to reenter the building nor reach the facility by phone for reentry after hours or after outside visitation with family and friends. Findings include: Facility Resident Council On 09/04/2025 at 10:30 AM, seven (7) confidential group of residents and a family member (who wished to remain anonymous) attended the Resident Council (RC) Meeting. The council has invited a Family Member#8 (FM8) during the Resident Council Meeting to attend on 09/04/2025 at 10:53 AM. The FM8 expressed that the resident's prescription glasses had been missing for almost a year, and there has been no follow-up in finding the glasses, nor have there been any resolution or efforts made to replace the missing glasses. The resident was described by FM8 as unable to express or speak for himself but still able to see, watch TV, and wear his glasses. FM8 revealed that she had expressed this frustration to staff, but nothing has been done regarding his prescription glasses. FM8 and other confidential group of residents had expressed their frustration about the difficulty they experience when staff does not answer the facility phone. One resident reported, when the office is closed, and receptionist is gone, no one answers the phone. There are too many prompts on the answering machine, so you have to leave a message on the voicemail. They don't call back after 5:00 PM. Confidential Resident #2 expressed frustration during the Resident Council meeting about the visitation hours rules. Resident #2 recalled going out with her friend, who visited her from out of town, and returned after 5:00 PM. It took her over an hour to get her friend inside the building. Her visitor waited for her to get into the building and did not want to leave her outside. It was getting dark for her visitor to drive back home, and she was worried about her visitor's safety driving alone in the dark. She indicated that they had called the facility over and over, tried every prompt, and left messages, but no one replied until one of the staff members coming from outside let her in. Confidential Resident #6 during the RC meeting .09/04/2025, 11:21 AM, revealed that he was unable to return to the building after he rang and rang the doorbell and called the after-hours facility phone number posted outside the locked back door for half an hour. The front door closes automatically after office hours. Residents are expected to use the back door after office hours. Confidential Resident #6 revealed that a couple of weeks ago, he visited his brother's house, and his brother signed him out. Resident #6 explained, It was around 10:30 PM. We were told we could stay out as long as we returned before midnight, so we made it back at 10:30 PM since my brother lives over an hour away. I had to go back to his house and come back the next day. I did not have my medications that night and morning. I did not return to the facility until the afternoon the following day (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because that's the only time his family was available to give him a ride. No one had called my brother to find out where I was or what had happened. The Social Services Director was interviewed on 09/04 2025 at 12:04 PM, confirmed that the resident had a court-appointed guardian and must have a preapproval to visit his brother and his family from his guardian. She stated that, 'no one is at the front desk after five. The doors are closed. After-hours Phone lines are supposed to be picked up by staff, and different units have prompts. Staff are supposed to answer them. The Administrator admitted to the surveyor on 9/4/25 at 12:30 PM, revealed the ongoing phone issue since he started as the facility administrator in January 2025, and they are working on it from the corporate level. The Administrator explained that the front door is locked from the outside after 5 PM, and no receptionist is scheduled to be by the front door after 5 PM. There is also no one to hear the backdoor buzzer (doorbell) because it only goes to the receptionist, and there's no one after 5 PM. The after-hours phone does not appear to be working effectively. They don't get answered. Facility policies were reviewed on 9/9/25 at 2:00 PM. It revealed: Resident Rights Policy (Last revised on 9/2018, Approved on 9/2018) Policy: It is the facility policy to implement procedures to protect residents' rights. GOAL: To ensure residents rights are protected. To ensure that all employees know and understand the resident's rights. To ensure each resident of the facility is provided a copy of his/her rights in writing upon admission… Spend time with Visitors; you have the following rights: to spend private time with visitors. To have visitors at any time, as long as you wish to see them, as long as the visit does not interfere with the provision of care and privacy rights of other residents… 2. The Visitation Hours Policy submitted by the facility (undated) revealed: Residents receive visitors when they wish to. Personal Property A record review of the Face sheet and electronic medical record/emr indicated Resident #22 was admitted to the facility on [DATE] ad readmitted on [DATE] with diagnoses: Multiple sclerosis, gait abnormality/stiffness, neuromuscular bladder dysfunction, history of urinary tract infections, glaucoma, and anxiety. The resident had a Brief Interview for Mental Status/BIMS score of 15/15 indicating full cognitive abilities. On 9/03/2025 at 12:05 PM, interviewed Ombudsman “K”, she said she was at the facility (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to talk to Resident #22” who said she was missing clothes amounting to $22.00. Ombudsman “K” said she had spoken to the Administrator several times about this. The Ombudsman was asked if she spoke with the Administrator on this day and she said she had not; She then met with him and came back and said nothing had been done about the resident's missing items. On 9/03/2025 at 12:27 PM, the Administrator was interviewed, and he was asked about Resident #22's missing items. He said she had missing clothes and forgot that he replaced them already. The Administrator was asked if he had a receipt that indicated he had replaced the resident's missing clothes or some form of documentation that he replaced them; He said he didn't have any but thought he might have an Amazon receipt. He was asked to see it. On 9/04/2025 at 9:30 AM, interviewed the Administrator and he said he did not have any documentation that he replaced the resident's items or what the items were. He could not say when they were replaced. On 9/05/2025 at 9:23 AM, Resident #22 was interviewed in her room. She was up in her wheelchair, alert and oriented x4. She said that she had a missing purple outfit from amazon- purple leggings and a purple sweatshirt that go together. She said she had spoken with the Administrator several times and he said he had already sent her an outfit, and she must not have received it; she said she did not receive a new outfit. She believed she was not being told the truth. On 9/05/2025 at 11:30 AM, Activities Director “L” was interviewed. She said she handled missing items for the residents. She said there was a Grievance form for missing items. The Activities Director said once an item was reported missing the information was placed on a Grievance form and she and her staff would look for the item in the resident's room, search their closet, laundry room, etc. and the item would be replaced if not located. During the interview with the Activities Director on 9/5/2025 at 11:30 AM, she said Resident #22, reported missing clothes a few months ago. She said the Administrator was aware that they could not locate it. She said she would look for a Grievance form for the missing clothes. On 9/05/2025 at 12:04 PM, the Administrator said he met with the resident and gave her $23.00 to replace her purple outfit. He said he did not have a receipt, Grievance form or proof that she received that. He said he would obtain a receipt. On 9/5/2025 at 1:30 PM, spoke with Resident #22, she said she received $23.00 for her purple outfit from the Administrator, and she said she would buy a new outfit. A review of the facility policy titled, “Resident's [NAME] of Rights,” date reviewed 1/25 provided, “Policy: It is the facility policy to implement procedures to protect resident rights… You have the right to be treated with dignity and respect… Make Complaints: You have the right to make a complaint to the staff of the nursing home… The nursing home must address the issue promptly…”

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Code Status was accurately documented and accessible in the medical record Care Plan for one resident (#21) of 1 reviewed for Advance Directives, resulting in the potential for miscommunication of code status which could lead to a lack of appropriate interventions for care.Resident #21 Advance Directives NotesA record review of the Face sheet and electronic medical record indicated Resident #21 was admitted to the facility on [DATE] with diagnoses Dementia mood disturbance with anxiety, and weakness. Per the progress notes, Resident #21 was receiving Hospice services.A review of the Face sheet for Resident #21 identified, Code Status: (Advance Directives)- Code Status: DNR. A review of the Documents section of the electronic medical record identified an assessment form titled, Code Status Form for Resident #21. Do-Not-Resuscitate was checked and further provided, Patient Advocate Consent/Guardian Consent: I authorize that in the event the declarant/resident's heart and/or breathing should stop; no person shall attempt to resuscitate the declarant/resident. signed by the resident's Responsible Party on 7/31/2025. The physician signed the document on 8/7/2025. A record review of the physician orders for Resident #21 identified, Code Status: DNR (do not resuscitate) . dated 8/6/2025. A review of the Care Plans for Resident #21 identified the following: I am a Full Code, date initiated and created 7/31/2025. The Care Plan contradicted the resident's wishes to not receive resuscitation. On 9/04/2025 at 11:07 AM, Social Services Manager E was interviewed about the Code Status for Resident #21 identifying an assessment for DNR, the Face Sheet said DNR, the physician orders dated 8/6/2025 said DNR and the Care Plan for Resident #21 said Full Code. The Social Services Manager said the resident's Care plan was updated to DNR on this day 9/4/2025; almost 1 month after her Code status was ordered and over 1 month since her responsible party signed the DNR assessment form. The Social Services Manager said the Care plan was wrong and had been missed. A review of the facility policy titled, Advance Directives Policy, dated 6/2005 and reviewed 8/25 provided, General: When a resident is admitted to the facility, a discussion of advance directives will take place between the resident or family/resident representative, if the resident is incompetent, and the facility staff. This enable the staff to readily and clearly ascertain how to treat the resident in advance of an emergency.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PASARR assessments were completed yearly and posted into the residents' clinical record for two residents (R#7 and R#10) of 3 residents reviewed for coordination of PASSAR and Assessments.Findings Include:On 9/4/25 at 2:30 PM, a review of R7's Pre-admission Screening and Resident Review (PASARR) was conducted. It revealed that R7 did not have one on file for 2025. The last PASARR in R7's File was dated7/3/2024. No other PASSAR Forms were found in R7's Electronic Medical Record. On 09/04/2025 2:58 PM, R10's PASARR was reviewed. An outdated Level I PASARR was found dated 12/20/2021. Another outdated PASSAR Level I and Level II dated August 16, 2024, was found. There was no assessment dated 2025 posted. The social worker (SW) was interviewed on 09/04/25 at 3:00 PM and stated that, according to the facility's policy, the PASARR Assessment must be done within 25 days from admission and then annually. She admitted that she did not have the PASARR Forms uploaded into their electronic medical records (EMR). The SW revealed that the policy stated Annual reviews must be done, submitted, and posted into the resident's record. SW admitted she did not have them posted in the EMR. Shen, the SW, was asked who was responsible for ensuring it is accurately done yearly and posted. The SW revealed that it was her responsibility since she is the Social Services Director.Resident #7 (R7)According to the review of Resident #7's clinical record, on 9/3/2023 at 1:30 PM, R7 was [AGE] years old, admitted to the facility on [DATE], with the primary diagnosis of generalized muscle weakness and difficulty walking, dementia with obsessive compulsive disorders, depression, psychotic disorder with delusions, delirium, and mixed anxiety disorders, in addition to other diagnoses.Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 05/15. A score of zero to 07 means that the person has severe cognitive impairment. R7's Section GG of the same assessment date, 7/24/2025, indicated that R7 was dependent on all ADLs (hygiene, showers, and dressing) except for eating. R7 required supervision or touching assistance with eating. R7 is dependent on staff for all transfers and mobility, utilizing a wheelchair for mobility/ambulation. R7 physician's orders for Risperidone .5 mg/ml solution by mouth one time a day (0900) for delirium, Risperidone 1 mL by mouth one time a day for delirium (2100), Alprazolam oral tablet 0.25 mg, give one tablet by mouth every 8 hours as needed for General Anxiety Disorder (GAD).Resident #10 (R10)A review of R10's Electronic Medical Record revealed R10 was [AGE] years old, admitted to the facility originally on 12/20/2021. Her most recent readmission was 4/10/2025 with the diagnosis of difficulty walking, Dementia, Bipolar Disorder, Depression, and Anxiety Disorder in addition to other diagnoses. Medications for these diagnoses were Risperdal oral tablet 0.5 mg twice a day, Trazodone HCL oral 100 mg tablet at bedtime, and Lorazepam 1 mg oral tablet.According to R10 PASARR Level II dated 8/16/24, R10 was prescribed Cymbalta, Seroquel, and Aricept for Bipolar disorder, which was not in the list of the doctor's orders reviewed on 9/4/25 at 1210 AM.The facility's Pre-admission Screening and Annual Resident Review PASSR Policy was requested and further reviewed on 9/5/25 at 12:00 PM. A review of the facility's Pre-admission Screening and Annual Resident Review PASSR Policy (with a revised date of May 2024) revealed: Goal: PASARR will be used on admission as required by the federal government to identify individuals with mental illness or intellectuals with mental illness or intellectual disability or related conditions who are requesting admission to a nursing facility . 2. Social Services/Transition Coordinator (SS/TC) will review the DCH 3877/3878 following admission to ensure accuracy . 3. The SS/TC is responsible for monitoring DCH3877/3878 and ensuring that the information complies with state requirements .The 3877/3878 will be completed annually by the SS/TC .PASARR Level II Recommendations will be incorporated into the resident's Plan of Care .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a wound was assessed with appropriate treatment for one resident (R6) and hospice orders were in place for two residents (R60 and R65) of three residents reviewed for quality of care, resulting in missing treatments for a wound and the absence of hospice treatment orders.Findings include: Resident #6 Skin Conditions A record review of the Face sheet and electronic medical record indicated Resident #6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Diabetes, dementia, chronic pain, arthritis, depression, and anxiety. The resident had moderate cognitive decline and needed some assistance with care. On [DATE] at 11:21 AM, Resident #6 was observed sitting on the side of the bed. She had a red, scabbed area on the tip of her nose, and a red, raw area under her lip. The resident said she rubbed them and began rubbing them. On [DATE] at 9:32 AM, Resident #6 was observed resting in bed. She was awake and a larger red raw partially scabbed area was observed on the tip of her nose approximately 0.5 cm x 0.5 cm and under her lip approximately 0.3 cm x 0.3 cm. The resident was asked if she was receiving treatment to the areas and she said she was not sure what was being done about them. A record review of the physician orders revealed an order for the resident's nose Cleanse chronic nonhealing picking wound to nose with iodine, Pat dry with gauze, apply triple antibiotic ointment and cover with a Bandaid, dated [DATE]. There was no order for the wound under the resident's lip. A review of the Medication Administration Record/MAR and Treatment Administration Records/TAR for [DATE] and [DATE] revealed a treatment was identified as completed from [DATE], to [DATE]. The [DATE] TAR had documentation on days the wound care was completed [DATE], to [DATE]. On [DATE] at 9:50 AM, Nurse D entered Resident #6's room. He said he was caring for the resident. He was asked about the resident's wounds on her face, and he said there was a treatment to her nose, and he said he had already completed the treatment that morning. There was no evidence of an ointment or Bandaid on the resident's nose. He said she probably removed it. The resident said she had not had a Bandaid that day. Nurse D was asked if there was an assessment or treatment for the area under the resident's lip and he said he did not think so. Discussed with Nurse E the wound was also present on [DATE]. He said he would request a treatment to the wound, as the resident continued to pick at the wound. A review of the progress notes indicated there was no mention of a wound beneath the resident's lip. Resident #60 A record review of the Face sheet and electronic medical record/emr revealed Resident #60 was admitted to the facility on [DATE] with diagnoses: Alzheimer's Dementia, anxiety, hypothyroidism, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chronic kidney disease, and heart disease. The resident had severe cognitive loss and needed assistance with all care. The resident was receiving Hospice services. A review of a Hospice document titled, Plan of Care Update indicated the resident was to receive Hospice services from [DATE] to [DATE] A review of the Care Plans for Resident #60 revealed there was no mention that the resident was receiving Hospice services. On [DATE] at 2:40 PM during an interview with Social Services Manager E she said Resident #60 was receiving Hospice services. Reviewed the Care Plans did not mention this and there was no order for Hospice. Social Services E said the resident had received Hospice services off and on during her stay but currently received the Hospice care. Resident #65 R65 is [AGE] years old and admitted to the facility on [DATE] on hospice care. R65 had diagnoses that included major depressive disorder, degenerative disease of the nervous system, hemiplegia and hemiparesis following cerebral infarction and aphasia following cerebral infarction. R65 expired on [DATE] in the facility while on hospice care. On [DATE] at 11:58AM, record review revealed there was no order for hospice care to evaluate and treat R65. On [DATE] at 1:11PM, an interview was conducted with the Transitional Care Coordinator (TCC) E. TCC E was asked if there should've been a physician's order for hospice to treat R65. TCC E stated, yes there should be an order for hospice to evaluate and treat R65. TCC E was asked who is responsible for entering the order. TCC E replied, I can put the order in, providers can too or the floor staff can put the order in. TCC E was asked why they thought there wasn't an order entered. TCC E replied, I believe there is a miscommunication about who is putting it (the order) in. The floor nurses can do it, I can enter it and so can providers. Then in the end it just doesn't get done.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate supervision and revise the care plan to prevent falls for one resident (Resident #7) of three residents reviewed for falls and accidents. Findings include:Resident #7 (R7)According to the review of Resident #7's clinical record, on 9/3/2023 at 1:30 PM, R7 was [AGE] years old, admitted to the facility on [DATE], with the primary diagnosis of generalized muscle weakness and difficulty walking, dementia with obsessive compulsive disorders, mixed anxiety disorders, in addition to other diagnoses. and major depressions in addition to other diagnoses.Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 05/15. A score of zero to 07 means that the person has severe cognitive impairment. R7's Section GG of the same assessment date, 7/24/2025, indicated that R7 was dependent on all ADLs (hygiene, showers, and dressing) except for eating. R7 required supervision or touching assistance with eating. R7 is dependent on staff for all transfers and mobility, utilizing a wheelchair for mobility/ambulation. R7 was not assessed for standing nor attempted walking with or without staff assistance on July 24, 2025. The MDS dated [DATE], revealed she was always incontinent for both bowel and bladder elimination patterns.R7's Care plan reviewed on 9/9/25 at 12:01 PM, revealed: 1. Activities of Daily Living (ADL) Care plan was created on 9/19/22 related to Impaired balance. Interventions:Toilet Use- R7 required extensive assistanceTransfers: requires one person, extensive assistanceBed Mobility: requires one person or extensive assistance to help with bed mobilityAmbulation in therapy only, and R7 is working with Occupational Therapy OT to increase independence (No specific ADL task was noted)2. R7's Incontinence care plan was noted to remain coded as occasionally incontinent. It was not updated or revised since April 3, 2025, when Section H of the MDS specified that R7 was always incontinent for both bowel and bladder elimination patterns as of the June 24, 2025, assessment date.R7 was noted in the incident report to be found incontinent after she fell on 8/24/25. 3. R7's Potential for Fall's Care plan initiated on 5/07/2025 revealed, Potential for falls, Resident at risk for injury from falls was initiated on 9/19/2022 and last revised on 5/7/2025. The goal is to reduce the likelihood of residents experiencing a fall by the next review. There were no revisions or updates despite R7's fall on 8/24/25, noted. The Care plan remained Potential for Fall even if R7 had an actual fall with a minor physical injury.4. R7's Impaired Cognitive function related to dementia Care Plan Interventions/Actions was not updated according to R7's BIMS Score was five as of 7/15/2025 MDS assessment.On 09/03/3035 at 8:09 AM, the surveyor approached R7 in the dining room, sitting alone by the table. R7 was talking to herself and was not coherent with the questions asked by the surveyor. The surveyor observed bruising with dark brown, black, and purple in color found on the right forehead, around the right eye, and some on her cheek and face (right sided). Unit Manager Nurse B at the dining room area, when asked about the incident, revealed that R7 had recently fallen and was sent to the hospital. R7 did not appear in pain nor was in any signs of distress.A review of the facility Incident Report dated 8/24/25 at 14:10 (2:10 PM) revealed, Nursing Description: Patient was observed on the floor lying next to the bed. Patient was transported to the hospital by EMS (ambulance), and has a hematoma on the right forehead. Predisposing Physiological Factors: Confused and incontinent. Other information: The resident was seen within 2 hours before the fall. She was wheeled back to her room after lunch and requested to go back to bed. Call light within reach.The facility incident report provided no indication or mention of R7 being toileted from lunch in the dining room to being put into bed by her aide.According to the Incident Staff (written) Statement dated 8/24/25 at 2:20 PM. Type of Incident: Fall. Staff G wrote: I did not witness the incident. Observe the resident on the floor next to her bed. Had a lump on her forehead. Called the nurse for help. Last saw resident (R7) was when I assisted the resident back to her room and placed her in bed per her request. Placed call light within reach at about 1:30 PM.Staff G written (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement did not indicate that she had toileted R7 between the time she was at the Dining room for lunch and the time she was placed in bed. Staff G had mentioned in writing that R7 went to the hospital immediately.During the interview with Nurse H on 9/9/25 at 10:25 PM, she explained that R7 fell a couple of weeks ago, which caused her to have a bruise on her head. R7's fall was unwitnessed and was confused (BIMS was 5/15). R7 was transferred to the hospital because she sustained a hematoma on her right forehead and was unable to give an accurate account of what happened. When Nurse H was asked where the call light was for R7, she was sitting out in a hallway. Nurse (-) stated that R7 does not use the call light, so we keep an eye on her and anticipate all her needs. R7 does not have a pressure sore or ulcer currently. The facility's Hospital Transfer Record dated 8/24/24 at 14:10 (2:10 PM) revealed: Patient was observed on the floor, lying next to the bed. Patient has a hematoma on the right forehead. Vitals were obtained, Blood Pressure (BP) =133/81, Pulse (P) =61, Patient c/o (complained of) headache pain.Services that will be provided at the new facility: Further treatment for hematoma on the patient's right forehead related to (r/t) Patient being observed on the floor.A review of the Hospital record dated 8/24/25, R7 was diagnosed and treated for a head injury. A CT scan of the Brain without contrast was performed at the hospital on August 24, 2025. The results revealed, Clinical History: Trauma, [NAME]: Intact. Additional Findings: Large Right Frontal Scalp Hematoma seen. The Emergency Department (ED) Patient Discharge summary dated [DATE] was reviewed. Discharge instructions were given for Adult Head Injury.Fall Management Policy was reviewed on 9/9/25 at 12:20 PM. Policy: This facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed.Fall Prevention Guidelines: 3. The care plan will be reviewed following each fall, quarterly, annually, and when a resident is triggered for a significant change in MDS.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure consents were signed and behavior monitoring was provided for psychotropic medications for two residents (R13, R60) of two residents sampled for psychotropic medications, resulting in the lack of consents and behavior monitoring.Findings include: Resident #13 R13 is [AGE] years old and admitted the facility most recently on 08/23/2025, with diagnoses that include schizophrenia, major depressive disorder, anxiety disorder and dementia. On 09/05/2025 at 02:35PM, record review revealed that R13 has physician's orders for Fluoxetine 20mg (anti-depressant) and Risperdal 1mg (anti-psychotic). On 09/05/2025 at 02:40PM, record review revealed there was no physician's order for behavior monitoring. Record review also revealed a task (area where the Certified Nursing Assistants chart) titled Behavior Monitoring and Interventions. There were two entries noted, one on 8/18/25 and 8/24/25. No other entries had been made for R13. On 09/05/2025 at 2:42PM, an interview was conducted with Transitional Care Coordinator (TCC) E. TCC E was asked about the lack of behavior monitoring for R13. TCC E stated, we are working on a process where it (behavior monitoring) triggers a progress note when a medication is given. TCC E acknowledges there is an issue with behavior monitoring, but says the facility is working on it and working to improve the process. Review of the policy titled, Psychotropic Medications revealed: Initiating the use of Psychotropic Medications: 1. Prior to using any new psychotropic medication, the staff will document the behaviors and alternative interventions used and the outcomes of those interventions. For residents admitted to the facility on psychotropic medications, the behaviors and need for such a medication will be pulled from the referral information and listed in the EMR. 9. If an order is obtained for psychotropic medication, the resident/responsible part must be informed of the risks and benefits of the medication. The facility must obtain informed consent. If the resident/responsible part cannot sign the consent, phone consent will be taken with two nurses verifying the consent. This documentation will be placed in the medical record in the designated area. Resident #60 A record review of the Face sheet and electronic medical record/emr revealed Resident #60 was admitted to the facility on [DATE] with diagnoses: Alzheimer's Dementia, anxiety, hypothyroidism, chronic kidney disease, and heart disease. The resident had severe cognitive loss and needed assistance with all care. A record review of the progress notes indicated Resident #60 had a fall beside her bed on 8/9/2025 at approximately 2:05 AM. The resident sustained an abrasion on her left elbow. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an Incident and Accident Report dated 6/22/2025 at 11:45 PM the resident was observed on the floor by her bed. She sustained redness to her left forehead, and right knee and a skin tear on her left hand. A review of the physician orders indicted Resident #60 was receiving several psychotropic medications including antipsychotic and anti-anxiety medications: ABH Gel/Ativan 1mg, Benadryl 2.5 mg, Haldol 0.5 mg date started 8/25/2025; Risperdal 1 mg started 6/6/2024 and revised 7/7/2025; Xanax tablet 0.5 mg started 6/9/2025; Quetiapine 50 mg start date 6/1/2024. A review of the Documents tab in the electronic medical record in the Consents tab revealed there was no consent for the ABH gel that included Ativan (an anti-anxiety medication), Benadryl (a medication that can be sedating) and Haldol (an antipsychotic medication). A review of the Medication Administration Records for June, July, August and September 2025 indicated there was no behavior monitoring documented to indicate the medication was necessary or effective. There was documentation for adverse effects, but not the need for use. A review of the Tasks documentation tab in the electronic medical record/emr identified an entry titled, Behavior Monitoring & Interventions. A review of the past 30 days from 8/5/2025 to 9/4/2025 revealed there was no documentation of behavior monitoring. A review of the progress notes identified an entry on 8/25/2025 that Resident #60 scratched a staff member during care. There was no additional explanation if it was intentional or identification of interventions used to minimize or prevent the behavior. On 9/04/2025 at 2:38 PM, Social Services Manager E was interviewed about Resident #60 receiving psychotropic medications and said it had taken the resident a long time to get stable. She said the resident had been yelling, hitting, and scratching at people. She said the behaviors had improved, but still had some behaviors at times. The resident's medication was reviewed with the Social Services Manager and it was identified that on 8/25/2025 the ABH gel/Ativan/Benadryl/Haldol combination had an increased frequency to be administered, from every 6 hours to every 4 hours. Reviewed with the Social Services Manager that there was no consent in the medical record located for the ABH gel. During the interview with the Social Services Manager E on 9/4/2025 at 2:38 PM, she reviewed the medical record and identified there was no consent for the ABH gel. The behavior charting in the tasks section was discussed and confirmed there was no behavior charting in the Tasks section of the emr or on the Medication Administration Records. The progress notes had an entry on 8/25/2025 that the resident scratched a staff member, but no additional behavior charting was identified. The ABH gel was increased that day. The Social Services Manager asked if the resident was often sleepy because of the sedating effects of the psychotropic medications she was receiving, as she was noted to be sleeping until approximately 11:00 AM on 9/3/2025 and the resident had several falls. She said the resident usually got up later in the morning. A review of the Care Plans for Resident #60 identified the following: The resident displays behavioral symptoms related to: Dementia, (Resident #60) has behaviors of hitting, pinching, pulling, and scratching at staff; spitting out medication, biting staff, scratching at residents, attempting to stab staff with cutlery, date created and initiated 6/26/2024 and revised 7/8/2025 with Interventions including: Give psychoactive medications as ordered. Record behavioral (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms and side effects, date created, initiated and revised 6/26/2024. (Resident #60) uses antipsychotic medication, date created and initiated 9/10/2024 and revised 7/14/2025 with Interventions including: Monitor/record occurrence of target behavior symptoms, pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others and document per facility protocol, date created, initiated and revised 9/10/2024. On 9/04/2025 at 3:31 PM, the Director of Nursing/DON was interviewed about the antipsychotic medications including the ABH gel with Haldol that Resident #60 was taking. She said the resident had behaviors at times in the past; reviewed there was no documentation supporting this except for one progress note. She said there should be documentation. Also reviewed there was no consent for the ABH gel, and the dose was increased on 8/25/2025. She said they were looking at that.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to ensure resistance patterns of organisms were identified and reviewed in the antibiotic stewardship meeting, resulting in the potential exposure of infection and ineffective antibiotic use for all 52 residents in the facility. Facility Infection Control On 9/09/2025 at 10:48 AM during an interview with IP/Infection Preventionist H, she said she was new to the role. She started in December 2024 and completed the CDC/Center for Disease Control and Preventions Certificate training course for Long Term Care/LTC on 4/6/2025. When asked to review the Infection Surveillance data for the prior year, September 2024 through September 2025, The IP H said she began collecting Infection Surveillance in April 2025, and surveillance prior to that was completed by someone else. During the interview with IP H on 9/9/2025 at 10:48 AM, there was identified Infection Surveillance for July 2025 with line listings, analysis and reporting completed. There was no additional monthly Infection Surveillance for the year with line listings, analysis and reporting per the following: October 2024, November 2024 and December 2024 was identified to have some Infection surveillance line listings, but no summary/analysis for trends. January 2025, February 2025, March 2025, April 2025, May 2025, June 2025, did not have line listings, analysis or reports. Some months had individual Infection worksheets for some residents and some months had nothing. August 2025, no September 2025 surveillance data, no line listing, some resident surveillance, no summary report, no antibiotic stewardship reporting for months without Infection surveillance. On 9/9/2025 at 11:30 AM, the Infection Preventionist H was interviewed about the months with no Infection Surveillance data over the past year and she said that was how it was when she started in the role. The IP H was asked how she could track antibiotic resistance if there was no Infection Surveillance data that included infectious organisms, and infections and she said she couldn't. She said she could report antibiotic use, but there was no additional data related to what organisms or infections they were treating, if there were resistant organisms such as Multi-drug-resistant-organisms/MDRO's, if the antibiotics were appropriate or if there were any trends related to the infections.A review of the facility policy titled, Antibiotic Stewardship, dated 8/2018, revised 8/2021 and reviewed 8/2025 provided, Policy: It is the policy of (the facility) to maintain an Antibiotic Stewardship Program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview, and record review the facility failed to ensure residents were 1) Consistently assessed for Influenza and Pneumococcal vaccinations on admission, per Standards of Practice, 2) Provided an educational vaccination information statement for each vaccination, and 3) Documented vaccination information in the residents' medical record, which could potentially affect all residents, including Residents #27, #30, #68 and #70, reviewed for infections, resulting in the potential for exposure to Influenza and Pneumococcal disease, and severe illness. Findings include:FacilityInfection Control On 9/09/2025 at 11:25 AM, during an interview with Infection Preventionist/IP H, she was asked about resident vaccinations for Influenza/FLU and Pneumonia. She said she was currently working with a local pharmacy to implement a vaccination clinic in October 2025 to provide FLU, Pneumonia and Covid vaccinations for the residents. She said resident vaccinations were assessed on admission by the Admissions Coordinator N. The IP H said she thought the residents' received education about the vaccinations via a Vaccine Information Statement/VIS for each specific vaccination, but she wasn't sure because a different staff member Admissions Coordinator N talked to the residents on admission.The IP nurse said the residents' vaccination information was supposed to be placed in the electronic medical record, but she was unable to access the MCIR/Michigan Vaccination Portal to gather past vaccination history. She said she had recently talked to someone about getting access, but she did not have it yet. A review of the vaccination information from the electronic medical record for each resident identified the following information about vaccinations for Resident #27, #30, #68 and #70: Resident #27: there was no vaccination information for FLU, Pneumonia or Covid.Resident #30: there was no Covid vaccination information.Resident #68: there was no vaccination information for FLU, Pneumonia or Covid.Resident #70: there was no vaccination information for FLU, Pneumonia or Covid. On 9/09/2025 at 2:39 PM, Admissions Coordinator N was interviewed about resident vaccinations, and she said she informed the residents that vaccinations were offered at the facility, including Flu during flu season, shingles, Covid, Pneumonia, and RSV. When the admission Coordinator said the residents would then sign a form that they consented or declined the vaccinations. Admissions Coordinator N was asked if the residents were provided educations about each vaccination so they could make an informed decision of whether to accept or decline and she said she was not a nurse and did not provide that information. The admission Coordinator was asked if a current Vaccine Information Statement was provided for them to look over and review, she stated, I am not familiar with that (VIS). The Admissions Coordinator was asked if she had received training to talk to the residents about vaccinations and she said she had not. A review of the facility policy titled, Influenza and Vaccination, date revised 12/16/2022 revealed the policy had outdated information in it from the 2021-2022 Influenza season and did not mention providing the mandatory Vaccine Information Statement. The policy stated the consent would serve as education and once the consent was obtained a new consent was not needed every year: this contradicts professional Standards of Practice.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, and record review the facility failed to ensure that residents were 1) Consistently assessed for Covid-19, per Standards of Practice, 2) Provided an educational vaccination information sheet for each vaccination, and 3) Documented vaccination information in the residents' medical record, which could potentially effecting all residents, including Residents #27, #30, #68 and #70, reviewed for vaccinations, resulting in the potential for exposure to Covid-19 and severe illness. FacilityInfection Control On 9/09/2025 at 11:25 AM, during an interview with Infection Preventionist/IP H, she was asked about resident vaccinations for Influenza/FLU and Pneumonia. She said she was currently working with a local pharmacy to implement a vaccination clinic in October 2025 to provide FLU, Pneumonia and Covid vaccinations for the residents. She said resident vaccinations were assessed on admission by the Admissions Coordinator N. The IP H said she thought the residents' received education about the vaccinations via a Vaccine Information Statement/VIS for each specific vaccination, but she wasn't sure because a different staff member Admissions Coordinator N talked to the residents on admission.The IP nurse said the residents' vaccination information was supposed to be placed in the electronic medical record, but she was unable to access the MCIR/Michigan Vaccination Portal to gather past vaccination history. She said she had recently talked to someone about getting access, but she did not have it yet. A review of the vaccination information from the electronic medical record for each resident identified the following information about vaccinations for Resident #27, #30, #68 and #70: Resident #27: there was no vaccination information for Covid.Resident #30: there was no Covid vaccination information.Resident #68: there was no vaccination information for Covid.Resident #70: there was no vaccination information for Covid. On 9/09/2025 at 2:39 PM, Admissions Coordinator N was interviewed about resident vaccinations, and she said she informed the residents that vaccinations were offered at the facility, including Flu during flu season, shingles, Covid, Pneumonia, and RSV. When the admission Coordinator said the residents would then sign a form that they consented or declined the vaccinations. Admissions Coordinator N was asked if the residents were provided educations about each vaccination so they could make an informed decision of whether to accept or decline and she said she was not a nurse and did not provide that information. The admission Coordinator was asked if a current Vaccine Information Statement was provided for them to look over and review, she stated, I am not familiar with that (VIS). The Admissions Coordinator was asked if she had received training to talk to the residents about benefits and risks of vaccinations and she said she had not.