STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235651	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Noa Home for Senior Citizens	2900 Third Avenue South Escanaba, MI 49829

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review the facility failed to report Payroll Based Journal (PBJ) information to CMS (Centers for Medicare and Medicaid) resulting in inaccurate reporting of staffing levels with the potential to affect all 69 residents.Findings include:Review of the CMS PBJ Staffing Data Report FY (fiscal year) Quarter 1 2026 (October 1- December 31) revealed the metric Failed to Submit Data for the Quarter, One Star Staffing Rating Excessively Low Weekend Staffing, No RN Hours, and Failed to have Licensed Nursing Coverage 24 Hours/Day.During an interview on 4/29/26 at 9:27 a.m., Resident Account Representative I reported, I am responsible for submitting the PBJ information to CMS.I did not submit the information for that quarter [October 1-December 31] .During an interview on 4/29/26 at 9:34 a.m., the Nursing Home Administrator (NHA) acknowledged the data for the PBJ report was not submitted for the first quarter [October 1- December 31].

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure four Certified Nurse Aides (CNA's) [C D E and F] of five CNA's reviewed for competencies had the required yearly competency trainings, including demonstration in skills and techniques necessary to care for residents.Findings include:A review of facility staff personnel records revealed CNA C was hired10/11/22. CNA Cs personnel record did not demonstrate dated competency skills since 3/11/25.A review of facility staff personnel records revealed CNA D was hired on 7/13/23. CNA Ds personnel records did not demonstrate dated competency skills since 7/24/24.A review of facility staff personnel records revealed CNA E was hired on 5/21/24. CNA Es personnel records did not demonstrate dated competency skills since 5/21/24.A review of facility staff personnel records revealed CNA G was hired on 3/8/22. CNA Gs personnel records did not demonstrate dated competency skills since 6/11/24.During an interview on 4/29/26 at 8:12 a.m., Hurman Resource Manager H reported, The CNA's must have annual competency training.During an interview on 4/29/26 at approximately 12:30 p.m., The Nursing Home Administrator (NHA) acknowledged the identified CNAs did not have annual competency training.Review of Facility Assessment (FA) dated 3/26, read in part . Staff training/education and competencies.Annual evaluation of identified competencies for nurse aide staff. were required.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete an annual performance review for three Certified Nurse's Aides (CNA's) out of five reviewed at least every 12 months.Findings include:Review of facility personnel records demonstrated the following:CNA C was hired on 10/11/22with no performance review since 3/11/25.CNA D was hired on 7/13/23 with no performance review since 9/30/23.CNA G was hired on 3/8/22 with no performance review since 9/21/23. During an interview on 4/29/26 at 8:12 a.m., Human Resource Manager H reported, Staff have annual performance reviews.During an interview on 4/29/26 at approximately 12:30 p.m., The Nursing Home Administrator (NHA) acknowledged the identified CNAs did not have annual performance evaluations.Review of Facility Assessment (FA) dated 3/26, read in part .Staff training/Education and Competencies.Annual performance evaluations for all staff. Annual evaluations are stored in personnel file.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement infection control program components as evidenced by the failure to:Perform appropriate hand hygiene during water pass,Ensure an ongoing, systematic collection and analysis of infection surveillance data,Properly don personal protective equipment (PPE) and ensure droplet precautions were implemented for Resident #27,Maintain a Resident catheter in a hygienic manner, andEnsure resident care equipment was maintained in a cleanable condition for use.These deficient practices resulted in the potential for the spread of infectious organisms and disease within the facility with the potential to affect all residents within the facility.Findings include:1. Hand Hygiene During Water Pass On 4/27/26 at 1:08 p.m., Certified Nurse Aide (CNA) A was observed entering resident room [ROOM NUMBER] with 2 clean water mugs and exiting the room moments later with two used (dirty) water mugs held in their bare hands. The used water mugs were placed on the second, lower shelf of a rolling cart. No hand hygiene was performed. CNA A then took two clean water mugs into room [ROOM NUMBER] where a Contact Precaution sign was posted outside of the room door which stated, Check with Nurse Before Entering, STOP, In Addition to Standard Precautions (checked was) . Hand hygiene before entering room and after leaving room, gown, gloves, and dedicated equipment. CNA A exited contact precaution room [ROOM NUMBER] with two used water mugs, picked up two clean water cups and took them into room [ROOM NUMBER] without the performance of hand hygiene. When asked about the presence of the Contact Precaution sign, CNA A stated, This isn't my hall and I don't know these residents very well. CNA A completed distribution of fresh, water mugs and removal of used/dirty water cups/mugs on the 100-hall without the performance of hand hygiene during the entire observation. During an interview on 4/28/26 at 11:44 a.m., when asked if water pass had ever been observed for compliance with hand hygiene policies and procedures, IP B said she had never watched staff passing water to facility residents in the facility. IP B stated, I would expect hand hygiene to be performed in between each room they enter. With the contact precaution room, they should use a Styrofoam cup instead and make sure they are using the proper precautions going in and out (of resident rooms). During an interview on 4/28/26 at 1:42 p.m., when asked about the absence of hand hygiene during water pass on 4/27/26, CNA A acknowledged hand hygiene had not been performed when going between resident rooms, including the contact precaution room [ROOM NUMBER], when passing fresh water and removing dirty water mugs/cups to the residents residing on the 100 Hall. Review of the cdc.gov/clean-hands/hcp/clinical-safety/index.html, dated February 27, 2024, accessed 4/28/26 4:10 PM revealed the following Recommendations: Know when to clean your hands: Immediately before touching a patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Infection Control Surveillance and Tracking During review of the facilities Infection Control Program documentation on 4/28/26 at 11:01 a.m., Infection Preventionist (IP) B was asked to provide the April 2026 infection line listing and mapping. IP B stated, I haven't done my line listing for April 2026 yet. That is what I was working on today. I do the map (of facility infections) at the end of the month. Aprils' will be done at the end of the month. On 4/28/26 at approximately 11:05 a.m., Review of uncompiled April 2026 Resident infection surveillance data, with IP B, for Resident #12 (R12), included a completed McGeer's Criteria form, which revealed the infection was identified in March of 2026. During an interview after review of the documentation, IP B stated, [R12] was on an antibiotic in March (2026). This was a March Infection. IP B explained R12 had a Urinary Tract Infection (UTI) in March, and the McGeer's Criteria form had been completed for a UTI. IP B said the Electronic Medical Record (EMR) line listing involving R12's April 2026 antifungal concern was not completed because April was not completed yet. IP B stated, This was an error on my part. During an interview an 4/28/2026 at 11:11 a.m., when asked about why Resident #34 (R34) did not have infection surveillance documentation completed for review, including a McGeer's Criteria form, IP B stated, I put [R34] in the (EMR) dashboard but I don't have his paperwork filled out yet. R34 was present on the incomplete April 2026 EMR infection control line listing, but no criteria for the infection had been established. Review of the Infection Prevention and Control Program policy and procedure, dated 11/25, revealed the following, in part: .Objectives: The objectives of the Infection Prevention and Control Program Policies and Procedures are to .Provide surveillance that identifies possible communicable disease or infections that can spread from person to person in the facility . Responsibilities of the Infection Preventionist .4. Performs surveillance, including monitoring processes, data analysis and documentation . Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Resident #27 (R27) On 4/27/26 at 2:07 PM, an observation was made of R27's room where signage was posted for transmission-based precautions (TBP) related to droplet precautions and the door was wide open. The signage outside of R27's door revealed TBP indicating staff should wear dedicated equipment including a gown, gloves, N-95 mask, and eye protection prior to entering. Review of R27's electronic medical record (EMR), revealed that R27 had contracted influenza A on 4/17/26. An observation was made on 4/28/26 at 12:00 PM, of R27's entrance door to her room which was wide open even though she was under droplet precautions. During an interview on 4/28/26 at 11:44 AM, the Director of Nursing (DON) and Infection Preventionist / RN A were both asked about droplet precautions and replied, We try and keep the door closed if it is safe. Both the DON and RN A agreed R27 was safe to have her door closed under droplet precautions. On 4/28/26 at 3:35 PM, an observation was made of Registered Nurse (RN) M donning PPE and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entering R27's room without eye protection. RN M was interviewed after she exited R27's room and was asked why she did not have eye protection on and replied after reading the signage on the outside of R27's door, No, I guess I should have. An observation was made on 4/29/26 at 7:35 AM, of R27's entrance door to her room which was wide open and the signage indicated R27 was under droplet precautions. Review of policy titled, Transmission-based Precautions, dated 03/2025, read in part Policy: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission.DEFINITIONS.droplet precautions – refers to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucus membrane contact with respiratory secretions.11. Droplet Precautions.f. Based upon the pathogen or clinical syndrome, if there is risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn.Recommendations for Personal Protective Equipment (PPE).droplet.Mask – [NAME] a mask upon entry into the patient room or cubicle.Type and Duration of Transmission-Based Precautions / Recommended for Selected Infections and Conditions.Infection/Condition.Influenza (pandemic), Precautions: Droplet. Resident #11 (R11) Review of R11's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 3/24/25 with diagnoses that included: neurogenic bladder. The MDS Section H revealed R11 had an indwelling catheter [a flexible tube inserted into the bladder to continuously drain urine into an external bag]. During an observation on 4/27/26 at 2:12 p.m., R11, sat in his wheelchair and propelled the wheelchair with his feet down the hallway. R11's catheter bag dragged onto the floor at least two feet behind his wheelchair with urine visible in the catheter bag. Review of policy titled Indwelling Urinary Catheterization, Maintenance, and Care last revised 2/26, read in part .Monitor the foley catheter system.check that tubing and drainage bag are secure and in the proper position a. Ensure privacy of drainage bag.keep the collection bag below the level of the bladder and off of the floor. On 04/27/2026 at 4:29 PM while in the Station 2 Spa shower room the seat covering of a shower chair was observed with a hole in the seat, exposing the foam material below. Beige shower straps and black backrest pads were also observed hanging on the wall in this room. Certified Nursing Assistant (CNA) J stated these were used to assist with supporting residents during bathing. Two of the three large beige straps had coatings that were cracked and frayed around the holes that run up and down the straps. Two of the three smaller leather coated back supports had coatings that were cracked exposing the filler underneath the coating.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to respond to grievances for three Residents (#31, #43 and #52) of eight residents reviewed for grievances.Findings include:During a group meeting on 4/28/26 at 2:34 p.m., when queried about the facilities response to grievances R31, R43 and R52 reported the following:R31 reported, I have lost two pairs of jeans that were sent to the laundry quite some time ago (approximately 6 months) and I told the Activity Director (AD) L.I also lost a nightgown.R43 reported, The laundry lost a turquoise sweater, and it had been gone at least two months.I told the AD L.R52 reported, I wore a brand-new nightgown maybe three times and it had been gone since it went to the laundry.I didn't know the facility takes lost items and puts them on a table for all the residents to go through.Review of the grievance log did not reveal any grievances regarding missing clothing from R31, R43 or R52.During an interview on 4/28/26 at 4:28 p.m., ADL reported, When clothing goes missing I do not write up a grievance sheet about it.we don't do anything like that.R31's jeans had been missing for about 6 months, R43s sweater had been missing for over 2 months, and I really have not heard anything about R52's nightgown.I have not reported the missing items to the Nursing Home Administrator (NHA). The AD could not identify a process or procedure for missing items or a grievance procedure.During an interview on 4/28/26 at 4:40 p.m., the NHA reported, We don't have a form for missing items or a procedure for missing items.I have not heard about the missing items.there is a lack of communication regarding the missing clothing items. The NHA stated she would have expected staff to make her aware of any missing items. The NHA could not identify a process or procedure for missing items. Review of policy titled Missing Items last reviewed 4/25, read in part .To safeguard resident property to the extent possible to assure there is not misappropriation of resident property. Should an item be reported a missing, all efforts will be made to locate the item and/or provide restitution when warranted.A grievance policy was requested and was not provided by the facility prior to exit.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a bed hold notice for one Resident (#11) of four residents reviewed for hospitalization.Findings include:Resident #11 (R11)Review of R11's Minimum Data Set (MDS) assessment dated [DATE], revealed the most recent admission to the facility was on 3/24/25 with diagnoses that included: hip fracture.Review of Electronic Medical Record (EMR) revealed resident sustained a fall and was discharged to the hospital on 3/17/26. The EMR did not reveal a bed hold policy had been provided to the resident or responsible party.During an interview on 4/28/26 at 11:54 a.m., Resident Account Representative I reported, We do not give out the bed hold policy to residents that are on Medicaid when they go to the hospital.During an interview on 4/29/26 at 12:49 a.m., the Nursing Home Administrator (NHA) acknowledged a bed hold policy had not been given to the resident or responsible party.Review of policy titled Bed Holds and Readmission last reviewed 10/25, read in part .Bed hold information will be provided to the resident and/or responsible party within twenty-four hours of the temporary absence.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review the facility failed to ensure an indwelling urinary catheter device was medically necessary and physician orders were in place for one Resident (#23) of two residents reviewed for catheters.Findings include:Resident #23 (R23)Review of R23's electronic medical record (EMR), revealed an admission to the facility on 4/17/26, with medical diagnoses including retention of urine and fracture of the right tibia.An observation was made on 4/27/26 at 2:52 PM, of R23 in her room with a urinary catheter bag hanging on the left side of her bed. R23 was asked why she had a urinary catheter and replied, I am not sure why. I suppose it is just for convenience.Review of R23's EMR revealed no physician order for the urinary catheter indicating size of tubing and balloon anchor to secure the catheter to the inside of the bladder.On 4/28/26 at 3:40 PM, an interview was conducted with Supervisor/Registered Nurse (RN) K who was asked about orders for indwelling urinary catheters and replied, It should have an order for balloon size and size of Foley tubing. I am not sure about measuring output.Review of R23's EMR, revealed physician orders dated 4/20/26 to change foley and obtain urine sample for UA (urinalysis) with C&S (culture and sensitivity), and on 4/25/26 a one time only order for catheter change after 24 hours of Fluconazole therapy. R23's progress notes lacked any documentation regarding removal or reinsertion of the urinary catheter which was completed on 4/20/26 and 4/25/26 per the April 2026 Treatment Administration Record (TAR).On 4/28/26 at 3:35 PM, an interview was conducted with RN M who was asked about adding orders for new admissions and replied, I am not sure about who adds the orders. The nursing supervisor usually adds the orders and double checks the orders added by nursing.During an interview on 4/28/26 at 3:45 PM, the Director of Nursing (DON) was asked if orders should be in place for residents that have indwelling urinary catheters and replied, Yes and there should be orders for balloon size and catheter size. The DON confirmed R23 had no orders for an indwelling urinary catheter and was not sure if hers was to be measured for output.On 4/29/26 at 10:30 AM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked if the facility had a bladder scanner and why toilet training was not attempted for R23 and replied, Yes, we have a bladder scanner. We should have attempted to remove the urinary catheter after she arrived at the facility. The NHA was asked about physician orders and documentation regarding the changing of the indwelling urinary catheter and replied, Yes, there should be a physician's order and nursing should have documented changing the catheter and I am not sure if this was completed lacking the documentation.Review of policy titled, Indwelling Urinary Catheterization, Maintenance, and Care, dated 02/2026, read in part Policy: It is the policy of this facility to use indwelling urinary catheters only when medically necessary and provide catheter maintenance and care following evidence-based guidelines. Procedure, Straight or Indwelling Urinary Catheter Insertion.17. Document per facility protocol.Procedure for Discontinuing for Indwelling Urinary Catheter.Document per facility protocol.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assess the risk of entrapment, review bed rail risks and benefits with the resident/resident representative and obtain consent and a physician order prior to the installation of bed rails for 1 Resident (#19) of 1 resident reviewed for bed rail safety. This deficient practice resulted in the potential for bed entrapment and risk of injury and death.Findings include:During an observation on 4/29/26 at 7:30 a.m., R19 was observed lying in bed. A breakfast tray was positioned on an overbed table but R19 was unable to eat independently. Bilateral quarter bed rails were present at the head of the bed on both the left (exit side) and the right (wall side) of the bed, with the head of the bed elevated to approximately 45 degrees. R19 did not respond visually or verbally to conversational questions.Review of R19's Minimum Data Set (MDS) assessment, dated 4/20/26, revealed R19 was admitted to the facility on [DATE] with active diagnoses that included the following, in part : stroke, heart failure, atrial fibrillation, aphasia, and hemiplegia (paralysis of one side of the body). Section B: Hearing, Speech, and Vision revealed R19 had No speech- absence of spoken words and was rarely/never understood and rarely /never understands when spoken to. R19's Cognitive Skills for Daily Decision Making were documented in Section: C as 3. Severely impaired - never/rarely made decision. Function Limitation in Range of Motion in Section: GG detailed bilateral upper extremity impairment, bilateral lower extremity impairment, with dependent (resident does none of the effort) assistance required for: eating, oral hygiene, toileting, shower/bathing, rolling left and right, sit to lying, lying to sitting, sit to stand, chair/bed-to-chair transfer, and toilet transfers. R19 used a wheelchair for mobility. Section P: Restraints and Alarms had no restraint or alarm use documented by R19.Review of R19's Medical Determination on 4/29/26 at 7:41 a.m., revealed R12 was unable to make their own medical decisions. Review of R19's Bed Mobility Care Plan on 4/29/26 at 7:52 a.m., revealed the following, in part: BED MOBILITY: The resident is dependent on 2 staff for bed mobility, repositioning and turning in bed. He can also have bed rails on his bed to improve bed mobility and repositioning. Date Initiated: 04/06/2026 Revision on: 04/06/2026.During an interview on 4/29/26 at 7:54 a.m., when asked about R19's ability to use the bilateral bed rails, Certified Nurse Aide (CNA) R confirmed she regularly provided care for R19 and stated R19 could grasp one side rail, because his right side was affected by a stroke and resulted in paralysis. During an interview on 4/29/26 at 8:11 a.m., when asked if there was a physician order in place for R19's bilateral bed rails, Registered Nurse Supervisor (RN) S stated, There should be. RN S said physical therapy evaluated residents for bed rails and made the order (for the bed rails) and maintenance then placed bed rails on the bed. When asked for R19's bed rail consent form, RN S stated, It (bed rail consent form) should be filed right here under consents in the R19's hard chart. RN S reviewed each document in R19's hard chart and Electronic Medical Record (EMR) and was unable to find a bed rail consent form for the bed rails in R19's complete medical record. RN S stated, I am not finding a (bed rail) consent (form). When asked if there was a physician order or signed consent for R19's bed rails, RN S confirmed no physician order was present for the bilateral bedrails in current physician orders, and stated, I am not finding a consent. During an observation on 4/29/26 at 8:38 a.m., during bed repositioning performed by CNA R and an unidentified CNA, R19 was able to use the right bed rail with his left hand, but use of the left, bed rail was only accomplished by staff placing his paralyzed hand onto the bedrail. Independent use or clasping of the left bed rail was not demonstrated by R19. During an interview on 4/29/26 at 12:19 p.m., the Nursing Home Administrator (NHA) and IP B were both asked for a copy of the facility bed rail policy. The NHA stated, We do not have a bed rail policy. A Restraints policy, updated 2/2026, was provided by the facility.During an interview with the NHA and Infection Preventionist (IP) B on 4/29/26 at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235651	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Noa Home for Senior Citizens	2900 Third Avenue South Escanaba, MI 49829

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately 12:30 p.m., the NHA again confirmed the absence of a Bed Rail policy. IP B reported review of R19's complete medical record and confirmed no bed rail assessment, physician order or consent was found for R19's bed rails.Review of the Restraints Policy and Procedure, updated 2/2026, revealed the following in part: . ?Physical Restraint' refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body . 1. The resident must be assessed prior to the initiation of any form of device or medication which meets the criteria of a restraint and periodically reassessed as their needs change throughout their stay. 2. If a resident is admitted to the facility . the facility must conduct an assessment to determine the existence of medical symptoms that warrant the continued use of the restraint . 4. Document in the resident's medical record the medical symptom being treated, alternative interventions that were used to treat the identified medical treatment and were ineffective.5. The medical record must include a physician order for the specific type of restraint. 6. Consent for restraint use is obtained prior to use from the resident or responsible person and filed in the medical record. 8. If there are no medical symptoms identified that required treatment, the use of the restraint is prohibited.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure a narcotic medication was stored and or consumed in a safe and secure manner for one Resident (#23) of seven residents reviewed for medication storage.Findings Include:Resident #23 (R23)On 4/29/26 at 7:30 AM, an observation was made of R23 lying in bed in her room. R23 had an empty medication cup on her floor upside down. R23 had a second medication cup on her bedside table with a small single round white pill inside. R23 was asked about the medication left in the cup and replied, I did not want to take it. I get all bound up if I take my oxycodone. R23 was asked if she was in any pain and what she would like to take for her pain and replied, My pain is at a 4 and I would like some Tylenol.During an interview on 4/29/26 at 7:35 AM, Licensed Practical Nurse (LPN) P was made aware R23 did not take her oxycodone and would like Tylenol instead. LPN P stated she did not dispense the oxycodone to R23, and rather indicated LPN Q had dispensed the oxycodone. LPN P reviewed the medication narcotic administration record which revealed LPN Q dispensed R23's oxycodone at 4:47 AM on 4/29/26.On 4/29/26 at 7:50 AM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked if R23 had an order to self-administer medication or if medications should be left at the bedside and replied, I am not sure if she has an order to self-administer medications. The NHA agreed medications should not be left at the bedside and nurses are to ensure medications as consumed at the time they are dispensed.At 10:35 AM on 4/29/26, the NHA confirmed R23 did not have a physician order to self-administer medications.Review of policy titled, Medications Administration, dated 02/2026, read in part Policy: It is the policy of this facility to ensure medications are given as prescribed, safely, and in a timely manner, while observing Resident's rights.