STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235652	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Timbers of Cass County	55432 Colby St Dowagiac, MI 49047

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings include: On 1/6/26 at 10:42AM, three boxes of nutritional supplements (chocolate, vanilla, strawberry) were found in the walk-in cooler with each box containing 24 to 36 cartons. Further review of the boxes found the strawberry box with a facility date of 11/18/25 and the chocolate and vanilla boxes with a facility date of 12/17/25. An interview at this time with Dietary Supervisor (DS) Q found that the dates on the boxes are usually the date the boxes are pulled from the freezer. When asked how long the items are good for, Kitchen Supervisor (KS) G stated the cartons are listed with an expiration date. A review of the cartons found the expiration date listed is for the product while frozen, and the cartons state the product is only good 14 days from Thaw. A further review of the walk-in cooler found an open package of hot dogs with no date to indicate discard. On 1/6/26 at 12:23 PM, observation of the Birch Pantry with DS Q, found three open containers of thickened juice, in the refrigeration unit, were found with no date to indicate discard. A review of the containers stated the juice was good up to 7 days under refrigeration. An interview with DS Q found that dietary staff date the items when they bring them down, but nursing should be dating these when they open them. Further review of the refrigeration unit found an open container of soup dated 12/27/25. According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use by date based on FOOD safety .According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) .On 1/6/26 at 11:05 AM, observation of the stand-up mixer found a clear plastic bag covering the mixer. An interview with DS Q found that the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	large mixer is only used three or four times a month, and that the bag helps keep it clean between uses. Observation of the mixer, once the bag was removed, found heavy accumulation of stuck on white debris encasing the back shield of the unit. On 1/6/26 at 11:10 AM, observation of the inside ceiling of the kitchen microwave found an increased accumulation of dried splatter debris. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.On 1/6/26 at 3:46 PM, a follow up tour of the walk-in cooler found a large zip lock bag, sealed shut, with shredded pork loin leftover from lunch service. An interview with KS G found that lunch service ended around 12:30 PM and after the pork set out to cool, it was placed in the zip lock bag and put into the walk-in cooler around 1:00 PM. When asked if there was ever a temperature taken of the product to see where it was in the cooling process, KS G stated no. At this time, KS G and the surveyor each took the temperature of the pork roast and found it to be 90F-95F.According to the 2022 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. According to the 2022 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected

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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. Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the potential for increased risk of respiratory infection among all residents in the facility.Findings include:On 1/6/26 at 1:25 PM, an interview with Maintenance Supervisor C, regarding the facilities Water Management Plan, found that the facility flushes water fixtures weekly to help remove stagnant water. When asked if the facility measures disinfection levels in the water, MS C stated he has a water strip test he does monthly that indicates levels of free chlorine and other factors within the water. When asked if the facility had control limits (minimums / maximums) for maintaining free chlorine or other factors on the water strip, MS C was unsure. On 1/6/25 at 1:38 PM, observation of the water softener salt room found two uncapped water lines behind the large water softener system. When asked if he was aware of these fixtures and if they are flushed regularly. MS C stated he was not aware of the hidden fixtures and will add them to his list for flushing. A record review of monthly logs submitted, dated April - November, found seven water quality parameters listed on each monthly chart with no clear distinction of acceptable ranges representing control limits. Multiple missing entries were noted with two of eight months showing 0 parts per million free chlorine residual, with no corrective action noted.A record review of the facility provided Water Management Plan (WMP), reviewed a document entitled Water Pathogen Risk Reduction, not dated, found that an interdisciplinary Water Management Team should meet at least quarterly. The plan goes on to state, The team shall review the plan at least annually to verify that the plan is being followed and to validate the monitoring and control methods. Further review of the WMP found a section where meeting minutes would be stored, with templates for taking minutes, but not completed forms or documentation of an active Water Management Team or annual review.

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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** Based on observation and interview, the facility failed to maintain a clean and homelike environment for 4 residents (R91, R45, R5, and R14) of 4 residents reviewed for a safe, clean, and homelike environment resulting in a loud oxygen concentrator, unclean bed linens and wheelchair cushion, and holes in bed sheets, with the potential for a reasonable person to experience feelings of embarrassment, shame, and/or loss of self-esteem. Findings include:R91 Review of R91's Minimum Data Set (MDS) dated [DATE] indicated the resident was cognitively intact with a BIMS (Brief Interview Mental Status) score of 15/15. Section B- revealed R91's hearing was adequate. During an observation and interview on 1/6/2026 at 11:29 AM R91 stated his roommate (R45) had an oxygen concentrator that was very loud. It was so loud R91 and his roommate had to turn up the volume on their television to hear the television. Observed the oxygen concentrator in R91's room belonging to his roommate (R45) located at the foot of R45's bed and at the head of R91's bed. The concentrator was loud enough to be heard out in the hall with the door to the room closed. During an observation and interview on 1/7/2026 at 1:37 PM R91 stated he wanted to know why the oxygen concentrator was still in the room and a new quieter one had not been obtained yet. During an observation and interview on 1/7/26 at 1:43 PM, R91 stated he wished his roommate's oxygen concentrator could be changed out to a quieter one. The original one his roommate (R45) had was much quieter and easier to live with. The one currently in the room was very loud and interfered with watching television and sleeping. R91 stated he saw the oxygen supply company bringing in a new one for another resident and asked why his roommate had not gotten a quieter one yet. During an interview on 1/8/25 9:50 AM CNA (certified nursing assistant) J reported R91 had complained about the concentrator numerous times. R45 Review of R45's Minimum Data Set (MDS) dated [DATE], the resident was cognitively intact as indicated by a score of 15/15 on his BIMS (Brief Interview Mental Status). Section O revealed R45 received oxygen therapy and diagnoses included acute respiratory failure with hypoxia (lungs cannot get enough oxygen into the blood causing low blood oxygen levels), COPD (chronic obstructive pulmonary disease, and impaired vision. Review of R45's Physician's Order Summary, dated 6/25/25, revealed, Oxygen per nasal cannula at 2 liters continuous. During the observation on 1/06/2026 at 11:43 AM, R45 was sitting in a wheelchair next to his bed waiting for a new portable oxygen tank. The resident stated he needed oxygen from smoking for many years and wished he could get the original oxygen concentrator he had that was quieter than the current one he used. He had asked for a quieter oxygen concentrator from staff and was still waiting for one. R45 agreed that the oxygen concentrator was noisy and that it bothered both him and his roommate (R91). Further observation R45's living area exposed the resident's bed had blood stains (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and holes on his fitted sheets, and blood on his flat bed sheet and the pillow in his wheelchair. One hole in the fitted sheet was the size of a pencil eraser and the other approximately the size of a nickel. R45 stated he had a bloody nose the other day from his blood thinner medication and the blood was probably from that. He stated today, 1/6/25, was his shower day and the CNA had made his bed but had not changed his bed linens. During an observation and interview on 1/6/2026 at 11:59 AM, Licensed Practical Nurse (LPN) Y looked at R45's sheets and noticed the blood and holes, stating she would expect either the CNA or the shower aide to change R45's sheets when he went for a shower, when blood was first noted, and upon observing the holes. During an observation and interview on 1/7/26 at 1:43 PM, R45 was sitting in his wheelchair in his room wearing oxygen connected to an oxygen concentrator. The concentrator was loud enough to be heard in the hall through the R45's closed door. R45 said he and his roommate (R91) were told by staff they were going to check with (name of oxygen supply company) about a new and/or quieter oxygen concentrator but had not heard back from staff. R45 stated he was legally blind and couldn't see the blood or holes in his sheets and expected the facility to provide clean and intact bedding for him. He further stated he would not have lived at his home with blood or holes in his bedding. During an interview on 1/8/26 at 10:00 AM, Unit Manager (UM) E reported regarding R45 with R91 living in bed 1 and R45 in bed 2. Outlets in the room limited the location of the concentrator and the two residents liked the way the room was set up. Due to the oxygen concentrator noise level, the machine had been switched out twice before. R5 Review of R5's Minimum Data Set (MDS) dated [DATE], the resident was cognitively intact indicative by a score of 14/15 on her BIMS (Brief Interview Mental Status). Section GG-Functional Abilities revealed R5 was dependent for all cares, with diagnoses including nontraumatic intracranial hemorrhage (type of stroke affecting left non-dominant side), lack of coordination, contracture of muscle, and weakness. During an observation on 1/06/2026 at 2:01 PM, R5 had holes in her fitted bed sheets by her head. There were four holes between the size of a dime and nickel with many others smaller in size. During an observation on 1/7/26 at 9:15 AM, R5 had holes in her fitted bed sheets by her head. There were four holes between the size of a dime and nickel with many others smaller in size. During an observation and interview on 1/7/26 at 2:00 PM, R5 had holes in her fitted bed sheets by her head. There were four holes between the size of a dime and nickel with many others smaller in size. R5 stated she couldn't see them but would like to have sheets that were not raggedy. During an interview on 1/8/26 at 8:05 AM, Laundry Aide K stated, Any stained towels, wash cloths, pillowcases, sheets, or blankets that are seen in laundry are pulled, counted, and replaced. A lot of the older sheets are getting worn and are getting holes. These stained or worn linens should not be on the floor for resident use. During an observation and interview on 1/8/26 at 8:25 AM, Registered Nurse (RN) PP observed R5 in bed. RN observed holes in fitted sheet and stated, Aides (Certified Nursing Assistant-CNA) should (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	take care of that. During an interview on 1/8/26 at 8:40 AM, CNA F stated, I am assigned to (R5) today. If I notice holes in resident sheets, I'll change them. I haven't noticed holes in (R5's) sheets today. I worked with (R5) on Monday but not the last two days. During an interview and record review on 1/8/26 at 8:31 AM, Occupational Therapy (OT) CC stated, Linens with holes should be removed. The bloody sheets should be changed out as well. Sheets should be changed on resident's shower day and if they are soiled or torn. Resident #14 Review of an admission Record revealed Resident #14 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (progressive disease that impacts cognitive skills) and major depressive disorder (persistent depressed mood or loss of interest in activities causing significant impairment in daily life). Review of a Minimum Data Set (MDS) assessment for Resident #14 with a reference date of 10/20/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Review of a Care Plan for Resident #14 with a reference date of 3/22/14 revealed the following problem/goal/approaches: Problem: Alteration in ADLs (activities of daily living) Goal: (Resident #14) will be clean, well-groomed daily and will participate in cares to her fullest ability. Approaches: .involve resident in care and decision making as much as possible. During an observation and interview on 1/6/26 at 1:18pm, Resident #14 sat in a chair in her room. The sheets on her bed had large areas of reddish discoloration across the entire surface of the fitted sheet. A yellow and tan circular stain, approximately 12 inches in diameter, was noted in the center of her pillowcase. When queried, Resident #14 reported she was very displeased with the condition of her sheets and pillowcase and felt they were filthy and had not been changed for weeks. During an observation on 1/8/26 at 11:14am, Resident #14 slept in her bed. The stains on her pillowcase and bed sheets remained as described during the observation on 1/6/26. In an interview on 1/8/26 at 12:17pm, Certified Nursing Assistant (CNA) SS reported Resident #14 was independent with cares and she was not assisted unless she asked for something. CNA SS reported Resident #14 would allow staff to change her bed linens as needed and those should be changed on the residents' shower days. In an interview on 1/8/26 at 12:29pm, Resident #14 reported her bed linens remained soiled. Resident #14 stated You see my pillowcase, it's filthy. I feel like asking them (staff) if they'd like to sleep on that. I shouldn't have to ask them to change my pillowcase and sheets when they're dirty. It's disgusting.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was consistently provided with showers/bathing for 3 of 4 residents (Resident #31, #36, and #41) and nail care for 1 (Resident #41) of 4 residents reviewed for activities of daily living, resulting in unmet personal hygiene needs with the potential for decreased self-esteem. Findings include: Resident #31: Review of an admission Record revealed Resident #31 was admitted to the facility on [DATE]. In an interview on 1/6/26 at 1:07 PM, Resident #31 reported she had not had a shower since she had been admitted to the facility. Review of Orders dated 12/19/25 revealed, .Bath/Shower on Once A Day on Mon, Wed 06:30 AM - 02:30 PM.Review of Skin Monitoring - CNA/STNA Shower Review documents completed on 12/16/25, refused and signed by nurse (note Resident was admitted 11:45 AM), 12/18/25 signed by staff member, no nurse signature, and 12/23/25 refused three times but not signed by nurse. No other documented shower sheets in record. No progress notes in the record to support the refusals. Note: No care plan implemented which would support refusing showers. Review of Behavior Logs for October, November, and December 2025 revealed, no behaviors noted for refusal of care. Resident #36: Review of an admission Record revealed Resident #36 was a female with pertinent diagnoses which included rheumatoid arthritis (chronic autoimmune disease where the immune system attacks healthy joint tissue causing pain, warm, swollen joints), cellulitis of right and left lower limbs (bacterial skin infection causing red, swollen, painful, and warm skin, can spread and become serious), chronic pain, weakness, and need for assistance with personal care. Review of current Care Plan for Resident #36, revised on 6/20/24, revealed the focus, .Alteration in ADLs (Activities of Daily Living) - self-care and functional mobility may fluctuate r/t (related to) weakness, heart failure, rheumatoid arthritis. with the intervention .Allow resident time to perform and complete ADLs as able. Staff to provide assistance for completion of tasks as needed.In an interview on 1/6/26 at 1:18 PM, Resident #36 reported she would like to get her showers as expected as she was not receiving them as she should. Resident #36 reported she felt the facility needed more staff so she could get showers twice a week. Resident #36 reported she does get one a week, but they needed to be done more.Review of Orders revealed Resident #36 was to be provided with a shower every Tuesday and Friday, 6:00 AM to 5:00 PM. Review of Skin Monitoring - CNA/STNA Shower Review documents for Resident #36 revealed 11/4/25, refused and not signed by nurse, 11/18/25, refused and not signed by nurse, 12/12/25 not signed by nurse, 12/16/25, refused and not signed by nurse, 12/19/25, refused and not signed by nurse. Note: no other documented showers or refusals were in the medical record. No progress notes entered in the medical record for the refusals per policy. Review of Behavior Logs for October, November, and December 2025 revealed no behaviors documented for refusal of care. Resident #41: Review of an admission Record revealed Resident #41 was a male with pertinent diagnoses which included stroke, contracture (permanent tightening or stiffening of muscles, tendons, skin leading to limited range of motion and potential deformity) of multiple sites, left elbow, left hand, need for assistance with personal care, bed confinement, paralysis affecting left dominant side, diabetes, and abnormal posture. During an observation on 1/7/26 at 1:25 PM, Resident #41 was in his room lying in his bed, his fingernails were long, jagged, with black debris under them on his right hand. During an observation on 1/8/2026 at 9:20 AM, Resident #41's fingernails were jagged, long and had black dirt and debris in the nail. In an interview on 1/7/26 at 3:33 PM, Registered Nurse (RN) M reported the nurse's cut the resident's nail who have diabetes, when completing weekly routine skin assessments and would look to see if the nails were jagged, not sharp which could increase chances of scratches, open areas on the skin. RN would clean the nails if there were dirt and debris in the nails. RN G reported the CNAs (Certified Nursing Assistant) or Shower Aides would notify the nurse on shower days if the resident's nails would need trimming. Review of Skin Monitoring - CNA/STNA Shower Review documents completed on 10/1/25 refused, 10/3 refused, 10/10 refused, 10/22 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused and not signed by nurse, 10/24 refused, 10/29 refused, 11/7 no nurse signature, 11/12 refused and not signed by nurse, 11/14 refused and not signed by nurse, 11/21 refused, 12/5 refused, 12/12 refused, 12/19 refused. Note: No other shower sheets provided for the residents. Review of Progress Notes for Resident #41 revealed no documentation supporting the refusals for showers/baths. Review of Behavior Logs for October, November, and December 2025 revealed no behaviors documented for refusal of care. In an interview on 1/7/26 at 12:41 PM, CNA MM reported when she provided a shower to the resident, a shower sheet was completed, and the nurse would sign it. If a resident refused the shower, the staff would attempt to offer the shower again, if not, then refused was documented on the shower sheet and signed by the nurse. In an interview on 1/7/26 at 3:03 PM, Shower Aide SS reported when a resident refused a shower she would reapproach them three times and if the resident still refused, she would let the CNA assigned to the resident know, let the nurse for the resident know, document on the shower sheet the resident refused and have the nurse sign it. Shower Aide B reported for care refusals it would be logged in the behavior book for behaviors. In an interview on 1/7/26 at 12:46 PM, RN U reported first he would find out why the resident refused the shower, maybe they wanted the shower later in the day or by another staff member who had a better rapport with the resident. RN U reported if the shower was refused three times, it would be documented in the behavior log by the CNA, and the nurse would document in a progress note the refusal.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide resident centered activities designed to support leisure needs for 3 (Resident #70, Resident #60 and Resident #75) of 4 residents reviewed for activities, resulting in feelings of boredom and the potential for worsening symptoms of depression, as well as a decline in physical and cognitive well-being.Findings include:Resident #70: Review of an admission Record revealed Resident #70 was a female with pertinent diagnoses which included dementia, cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language), need for assistance with personal care, aphasia (language disorder from brain damage that impairs speaking, understanding, reading, or writing), and depression. Review of current Care Plan for Resident #70, revised on 11/7/2022, revealed the focus, .(Resident #70) prefers activities that identify with prior lifestyle. She likes to listen to music, watch tv, look at magazines, and she enjoys animals, as well as going outside . with the intervention .Provide activities that resemble the resident's prior lifestyle; Musical entertainment, special events, socials, religious activities .Provide materials of interest: Tv, magazine, word search, puzzles .Inform resident of upcoming activities by: provide activity calendar, verbal reminders, escort, encouragement . Review of Social Services note dated 11/24/25 at 8:30 AM, revealed, .Annual MDS (Minimum Data Set) assessments completed. Resident received a 2/15 BIMS (Brief Mental Status) . Note: Score of 2 indicated resident was seriously cognitively impaired. Review of MDS dated [DATE], revealed, a staff assessment was completed which indicated Resident #70's activity preferences were listening to music, being around animals such as pets, spending time away from nursing home, and spending time outside. Review of Progress Note dated 01/01/2026 at 11:10 PM, .Resident likes to do her own independent activities and attends activities of choice. No signs or symptoms of distress noted. Resident A & O (alert & oriented) to person, place, time. Resident up at nurses' station for most of shift, went to cafeteria for supper. Went to room for nighttime care .is able to make her needs known to staff . During an observation on 01/06/2026 at 1:14 PM, Resident #70 was seated across from the nurse's station along the wall by the entrance to the 300 hallway. In an interview and observation on 1/6/26 at 2:28 PM, Certified Nursing Assistant (CNA) W reported Resident #70 didn't want to go to Bingo this afternoon and she preferred to talk to her stuff animals in her room and that kept her busy. Resident #70 was observed seated across from nurse's station after lunch, head down, eyes closed, and legs crossed. During an observation on 1/7/25 at 1:15 PM, Resident #70 was observed seated across from the nurse's station and her eyes were closed. During an observation on 1/7/25 at 2:36 PM, Resident #70 was observed seated across from the nurse's station in her wheelchair. She was not speaking or talking with any residents or staff. During an observation on 1/7/25 at 3:32 PM, Resident #70 was seated up at the nurse's station, and (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the music was unable to be heard as this writer stood along the wall and was unable to hear the music which was at the other end of the wall closer to the entrance to the hallway and the area was quiet at the time. During an observation on 1/7/25 at 3:55 PM, Resident #70 was seated in the same location as the previous observation this time Resident #70 had her eyes closed. During an observation on 01/08/2026 at 9:20 AM, Resident #70 was observed in her room talking to her stuffed animals while she was lying in her bed. During an observation on 01/08/2026 at 1:15 PM, Resident #70 was seated the nurse's station in her wheelchair, she had her left hand on her head, and had her eyes closed. This writer had attempted to speak to Resident #70 who was pleasantly confused. When spoke to and asked questions, the resident made eye contact but did not provide meaningful or purposeful answers to question. Resident #70 was not observed participating in any scheduled activities during the duration of the survey. Review of Activities Charting Report for Resident #70 revealed, November 2025 Resident #70 participated in 4 group activities; for December she participated in 10 group activities. Resident #60: Review of an admission Record revealed Resident #60 was a male with pertinent diagnoses which included stroke, speech disturbance, and dementia, Review of current Care Plan for Resident #60, revised on 11/08/21, revealed the focus, .(Resident #60) prefers activities that identify with prior lifestyle. He enjoys listening to country music, watching tv, being outdoors, and people watching . with the intervention .Inform resident of upcoming activities by provide activity calendar, verbal reminders, escort, encouragement .Provide materials of interest: TV, movies, magazines, Provide occasional visits with resident for socialization and companionship, Provide pet visits as able, Provide activities that resemble the resident's prior lifestyle: outdoor, socials, special events, musical entertainment, exercise . Review of Social Services note dated 12/22/2025 at 10:45 AM, .Quarterly MDS and psychosocial assessments completed. Resident received a 0/15 BIMS, which indicates severe cognitive impairment . Review of Activities assessment dated [DATE], revealed, .Previous Occupation: Farmer/Mailman .Cognitive and/or Sensory Deficit Programming: Does resident require special programming - No, skip rest of section .continue current plan of care . During an observation on 01/06/2026 at 10:35 AM, Resident #60 was seated in his wheelchair directly across from the nurse's station. This writer attempted to speak with Resident #60 and the resident made eye contact but did not provide meaningful or purposeful answers to question. During an observation on 01/06/2026 at 2:27 PM, Resident #60 was observed seated next to Resident #70 and he was seated towards the end of his wheelchair seat, leaning forward with his eyes closed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/7/25 at 2:42 PM, Resident #60 was observed seated in his wheelchair in his room, he had his water cup by him on his rolling bedside table. He has his head down, and his hands clasped. Eyes were closed. During an observation on 1/7/25 at 3:32 PM, Resident #60 was observed seated in his wheelchair in his room, he had his water cup by him on his rolling bedside table. He has his head down, and his hands clasped. Eyes were closed. During an observation on 01/08/2026 at 9:17 AM, Resident #60 was seated at the nurse's station, his eyes were closed and he had his head down. During an observation on 01/08/2026 at 1:17 PM, Resident #60 was seated at the nurse's station in his wheelchair on the corner, couldn't hear the music as another resident was humming along. He could barely keep his eyes open and his head was tilted forward. Review of Activities Charting Report for Resident #60 revealed, November 2025 Resident #60 participated in 11 group activities, 1 family visit; for December he participated in 19 group activities, 1 family visit. In an interview on 01/06/2026 at 11:28 AM, Activity Director (AD) N reported she had developed an activity called healthy hands which was a sensory activity and she would provide residents with a washcloth to wash their hands prior to meals, she reported it was difficult to schedule an evening activity as dinner was not being served at a consistent time and the activity aide competed the last activity for the day at 5:00 PM. AD N reported she had concerns with residents being placed at the nurse's station listening to music which wasn't age appropriate for those residents aged in their 70s, 80s, and 90s, that the music was more modern like 90s and 2000s. In an interview on 1/8/26 at 1:49 PM, AD N reported when she had started at the facility staff were documenting on hard copies of various forms of paper, not a specific document. AD N reported she was having Activities Aide (AA) JJ sorting through loose papers to sort the documentation into months to later be entered into the medical record. AD N reported she had educated the activities staff on documenting one to one room visits with residents. Review of the Activity Calendar for January 6 - January 8th revealed, .1/6/26: 8:30 Daily Agenda, Reminders of Daily programs; 10:00 AM Daily Chronicles, Today's menu and Exercise; 10:30 National Bean Day, Healthy Hands; 2:00 PM Bingo; 3:30 PM Unit specific in room Hand Care Cart; 5:00 PM Air Hockey in the game room .1/7/26: Waffle Wednesday: Chocolate Chip Waffles; 10:00 AM, Daily Chronicles, Today's menu, and Exercise; 10:30 AM Calendar Committee, Health Hands; 2:00 PM January Birthday Celebration - Cake, Punch, and a Birthday game .1/8/26: 8:30 Daily Agenda, Reminders of Daily programs; 10:00 AM Daily Chronicles, Today's menu and Exercise; 10:30 Happy Birthday Elvis - Song quiz, Facts & The King Trivia; Healthy Hands; 2:00 PM Laura's Creations; 3:15 PM Bible Study led by Volunteer (First Name); 5:00 PM Penny Pitching . Review of Participating in Activities You Enjoy as You Age, published by the National Institute on Aging, 3/28/22, revealed: Research has shown that older adults with an active lifestyle: Are less likely to develop certain diseases. Participating in hobbies and other social activities may lower risk for developing some health problems. Studies looking at people's outlooks and how long they live show that happiness, life satisfaction, and a sense of purpose are all linked to living longer. Doing things that you enjoy may help cultivate those positive feelings. Studies suggest that older adults (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who participate in activities they find meaningful, .say they feel happier and healthier. When people feel happier and healthier, they are more likely to be resilient, which is our ability to bounce back and recover from difficult situations. Positive emotions, optimism, physical and mental health, and a sense of purpose are all associated with resilience.research suggests that participating in certain activities, such as those that are mentally stimulating or involve physical activity, may have a positive effect on memory — and the more variety the better. Other studies are providing new information about ways that creative activities, such as music or dance, can help older adults with memory problems or dementia. Resident #75 Review of an admission Record revealed Resident #75 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: multiple strokes (sudden loss of blood flow to an area of the brain causing symptoms like numbness, loss of movement, confusion or vision/speech deficits), major depressive disorder (persistent sad mood resulting in loss of interest, affecting daily functioning). Review of a Minimum Data Set (MDS) assessment for Resident #75 with a reference date of 12/14/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section D of the MDS revealed Resident #75 had little interest or pleasure in doing things and felt down, depressed, or hopeless nearly every day of the 14-day assessment period. Review of a Care Plan for Resident #75 with a reference date of 6/23/25 revealed the following problem/goal/approaches: (Resident #75) lacks sense of initiative/involvement as evidenced by R/T (related to) little interest or pleasure in doing things. Goal: Resident will not exhibit signs of isolation. Approaches: .attempt to involve resident with individuals who seem to bring out a more positive optimistic side of the resident, encourage resident to establish social role in the facility.involve resident with those who have shared interests, provide opportunity for resident's expression of individuality (e.g. what gave sense of satisfaction in earlier life). During an observation and interview on 01/06/2026 at 11:40 AM, Resident #75 sat at the edge of his bed. His room was quiet; the television was off. Resident #75 reported he was not interested in the types of activities offered at the facility, frequently felt bored and realized the lack of activity could worsen the symptoms of his depression. Resident #75 reported he worried about his mood worsening, but he could not do the types of leisure activities he used to enjoy and needed support to occupy his free time. In an interview on 1/8/26 at 9:41am, Activity Assistant (AA) OO reported Resident #75 did not attend any group activities at the facility and spent most of his time alone in his room. Review of an Activities Charting Report with a reference date of 12/25/25 revealed Resident #75 participated in 1 activity, Healthy Hands. Additional documentation of any group or 1:1 activity involvement for Resident #75 was requested but no additional documentation was provided prior to the conclusion of the survey. In an interview on 1/8/26 at 11:24am, Activities Director (AD) N reported she accepted her position a few months prior to this date and had not been able to evaluate Resident #75 to determine his leisure needs and interests. AD N reported the facility was working on developing a 1:1 visit program for (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents who preferred to remain in their rooms, but visits were not being consistently offered yet. In a follow up interview on 1/8/26 at 12:13pm, AD N reported following an evaluation on this date, she determined Resident #75 was agreeable to support with pursuing his leisure interests which included birdwatching, playing cards, and visiting with like peers. AD N reported she searched for Resident #75's activity participation records/1:1 visit documentation and could not find any additional record of his involvement. Review of an Activity Programming policy with a reference date of 6/17 revealed Policy: Activity programs designed to meet the needs of each resident are available on a daily basis. Our activity programs are designed to encourage maximum individual participation and are person-appropriate to the individual resident.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to ensure treatment and care to maintain foot health in 1 (Resident #36) of 1 resident reviewed for foot care, resulting in delay of treatment for podiatry concerns and pain/discomfort of Resident #36's feet. Findings include: Resident #36: Review of an admission Record revealed Resident #36 was a female with pertinent diagnoses which included rheumatoid arthritis (chronic autoimmune disease where the immune system attacks healthy joint tissue causing pain, warm, swollen joints), cellulitis of right and left lower limbs (bacterial skin infection causing red, swollen, painful, and warm skin, can spread and become serious), chronic pain, weakness, heart failure, and need for assistance with personal care. Review of current Care Plan for Resident #36, revised on 6/20/24, revealed the focus, .(Resident #36) has potential for /actual pain r/t (related to) rheumatoid arthritis and poly arthritis. with the intervention .Administer pain medications as ordered .Observe for nonverbal signs of pain; grimacing, moaning, increased vital signs, guarding area(s).Pain assessment every shift. In an interview on 1/6/26 at 1:18 PM, Resident #36 reported her feet hurt as well as she reported something blue under her toenails and would like to soak her feet. Resident #36 reported she thought maybe it was the lotion the nurse applied to her feet. She said she had seen the podiatrist before and he cut her toenails because they were crooked but he doesn't address the concern she had with the lotion and under her toenails turning blue. In an interview on 1/6/2026 at 1:26 PM. Licensed Practical Nurse (LPN) S reported Resident #36 liked Bio Freeze (topical pain reliever using menthol to provide for temporary relief) and Aquaphor (healing ointment to restore and soothe dry, cracked, or irritated skin) on her feet, but she had not mentioned the concern with under her toenails being blue. LPN S reported she would bring it up to the doctor by calling them to come and examine Resident #36's feet. LPN S reported she would go in to examine Resident #36's feet. LPN S reported the cream was a white color, so she was unsure why Resident #36 thought she had blue under her toenails. In an interview on 1/6/2026 at 1:35 PM, when queried LPN S reported she thought it was fungus underneath her toenails as she had big horned toenails (severely thickened, overgrown, and curved toenails resembling a ram's horn due to uneven keratin growth causing pain) on her feet and she would contact the doctor for some cream for it.In an interview on 1/7/26 at 1:21 PM, Resident #36 reported he feet hurt and wanted to have some relief. Resident #36 indicated she reported the pain to the nurse, and she was hoping it was not going to be long before she came and put the cream on her feet. In an interview on 1/7/26 at 1:36 PM, LPN S reported she thought it was a fungus, reported the doctor had been in to see the resident, and LPN S said she had placed Resident #36 on the list to see the podiatrist. When queried if she saw the doctor examine the patient, LPN S reported no, the doctor was standing outside the resident's door in the hallway, and nothing had been prescribed for Resident #36. When queried when the podiatrist was going to be in the building next, LPN S reported she did not know when. In an interview on 1/7/26 at 3:18 PM, Resident #36 reported the nurse had not come and applied the lotion to her feet and her feet really hurt. In an interview on 1/7/26 at 3:33 PM, Registered Nurse (RN) M reported if there was a concern for fungus or other concerns expressed by the resident, she would contact the doctor depending on the concern, and/or document in the doctor book for them to be seen during rounding. In an interview on 1/7/26 at 3:40 PM, UM E reported the MD/NP (Medical Doctor/Nurse Practitioner) were here today. UM E reported she had rounded with them; Resident #36 was not on the list and was not seen by the doctor today. UM E reported the doctor was not here yesterday as she had not been feeling well and came today instead. UM E reviewed the doctor's book to verify if Resident #36 was on the list and she verified she was not. UM E reported if there was a concern for a resident the nurse would place the resident's name in the doctor book, and the concern would get communicated to her as she rounded with the doctor. UM E reported the doctor was in the facility on Tuesdays and Thursdays and the Nurse Practitioner was in the facility on Wednesdays and Fridays. During an observation and interview on 1/7/26 at 3:48 PM, Unit Manager (UM) E reviewed (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #36's orders which revealed, she was prescribed Voltaren (cream or gel which treats arthritis pain by targeting pain directly at the source to deliver clinically-proven nonsteroid anti-inflammatory medicine) for her fingers and toes, BID (twice a day) between 06:00 - 2:00 PM and 03:00 PM - 10:00 PM. This writer asked UM E to review the medication administration record (MAR), and she reported it was documented in Resident #36's medical record she had received the Voltaren treatment during first shift, 06:00 - 02:00 PM. UM E was informed to speak to Resident #36 to verify the treatment had been provided. In an interview on 1/7/26 at 4:15 PM, MDS Nurse X reported Resident #36 was having her Voltaren cream applied at this time by the Unit Manager.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement interventions for positioning and contractures for 2 of 2 residents (R5 and R41) reviewed for range of motion, resulting in the potential for worsening of contracture and developing skin breakdown. Findings include: R5 Review of R5's Minimum Data Set (MDS) dated [DATE], the resident was cognitively intact indicative by a score of 14/15 on her BIMS (Brief Interview Mental Status). Section GG-Functional Abilities revealed R5 was dependent for all cares, with diagnoses including nontraumatic intracranial hemorrhage (type of stroke affecting left non-dominant side), lack of coordination, contracture of muscle, and weakness. During an observation and record review on 1/6/2026 at 2:01 PM, R5 had hand-written instructions that were highlighted, placed on the wall above the resident's head of bed. Place pillow under left forearm and hand to elevate for edema management. Place rolled washcloth in left hand for contracture management. Observed R5 for implementation of these devices and saw no rolled washcloth in left hand or a pillow under left forearm or hand. Observed two blue wedges on the floor in corner of room. No washcloths were visible in the resident's room. A second hand-written note was on the wall above R5's head of bed stating For Staff starting 1st shift; place rolled wash cloth in left hand at beginning shift. Remove at end of shift. It was noted to not be at the end of 1st shift. During an observation and interview on 1/7/26 at 9:15 AM, R5 stated she did not have a washcloth in her left hand because it would fall out because her hand moved. Staff told her they were going to get her a brace or something that would stay in her hand, but one had not been used yet. R5 stated there were no wedges or pillows under her left arm/hand or side. When staff moved her not too long ago her leg hurt and staff had not put anything under her hips to off-load the pressure on either side of her hips. R5 reported she did get uncomfortable at times and needed to move around but she could not move herself and needed staff to help her. She was hoping to be moved around a bit in her bed that day. During an observation and interview on 1/8/26 at 8:25 AM, Registered Nurse (RN) PP observed R5 in bed. RN PP observed left hand to not have a rolled washcloth, or a pillow/wedge under sheet to resident's left side. RN PP stated, (R5) will sometimes get the washcloth out of her hand or not let staff put the wedge under her left side. It should be documented when she refuses, and the unit manager is the one that updates the care plan if residents do not want something done or refuses. During an interview and record review on 1/8/26 at 8:31 AM, Occupational Therapy (OT) CC stated, (R5) is to have a washcloth in her left hand for contracture prevention and skin breakdown and is to be done by the care givers. Pillow or blue wedge under her left side under sheet to prevent resident's arm from falling off side of bed and is to be done by care givers. If a resident refuses this care, it should be documented either in nursing notes or behavior logs. Review of R5's OT Recert, Progress Report, & Updated Therapy Plan for certification period: 10/26/2025-11/24/2025 revealed, Start of Care: 9/26/2025.Long Term Goal #2.0 patient will compliant with using hand roll for 4 hours per day to decrease contracture.10/16/25 patient using (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only when therapy places; poor CNA follow up.10/26/25 patient using only when therapy places; poor CNA follow up.Short Term Goal #5.0 caregivers will complete daily positioning of LUE (left upper extremity (arm)) in elevation using pillows, wedges, and place rolled cloth in hand to manage joint and skin integrity.10/16/2025, 10/16/2025 education to be initiated/continued.10/26/2025 education continuing to CNA; follow up minimal. It was noted CNAs had poor follow up providing hand rolls for R5 and that there was no care plan in R5's medical chart for nursing staff to implement interventions recommended by Occupational Therapy. During an interview on 1/8/26 at 8:40 AM, Certified Nursing Assistant (CNA) F stated, A washcloth and wedge were frequently refused by (R5). I report it to her nurse. CNAs are to document in the behavioral log when a resident refuses treatments or cares. I don't remember if I chart her refusals. Review of R5's Behavioral Log Flow Sheet for October 2025 and November 2025 noted no documentation of any kind of behaviors had been done for either month. Review of R5's Behavioral Log Flow Sheet dated December 2025 indicated on 12/30 at 9:25 AM, the resident was 1 (refuses care with no specific details), 2 (Frustration/escalating behavior with no specific details), and 3 (argumentative) during ADL (activities-of-daily-living). It was noted no specific details on what kind of ADLs attempted to be done for the resident or if the behaviors were directed towards positioning or use of washcloth. It was noted the Behavioral Log Flow Sheet required specific details for refusals and the staff that documented failed to do so. Review of R5's Behavioral Log Flow Sheet on 1/8/26 at 8:49 AM for January 2026 noted no documentation of any kind of behaviors had been done from 1/1/26 to 1/8/26 at 8:49 AM. During an interview and record review 1/8/26 9:46 AM, Unit Manager (UM) E stated, I do not see an order for (R5) to have a washcloth in her left hand or the wedge under her left side. CNAs document in their charting or the resident's behavior log book and notify the nurse. If the nurse does not chart in their nurse's notes it should be in the behavior log book and if it becomes a regular refusal, depending on what the resident is refusing it is up to the myself for resident specific concerns to make a care plan specific to the refusals. I am the Unit Manager for (R5). I do see OT (Occupational Therapy) notes for (R5) to use hand rolls for 4 hours a day to decrease contractures. This was dated 10/26/25. It does say patient use only when therapy places the hand rolls. The OT notes also say (R5) is reluctant to reposition but (R5) is pretty good at allowing repositioning. The pillow is used for left upper extremity (left arm) to manage joint and skin integrity. The OT note does not specifically say who places the pillow and that CNAs are to receive ongoing education and nursing should be placing it 10/26/25. If a resident is refusing these cares/treatments, they should be documented in behavior log by CNAs and if the resident continually refuses it should be reevaluated by the nursing staff. I would be one of the staff that would put the refusals in the care plan. There is not a care plan for what the OT has recommended for (R5). Review of R5's Care Plan, Skin Integrity, start date 10/27/2022, revealed, .Skin Integrity (R5) is at risk for skin breakdown related to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.decreased mobility/dependent with self-care and mobility. Goal (R5) skin will remain intact. Interventions: 10/27/2022 Encourage and assist as needed with turning and repositioning as (R5) will allow. It was noted there was not a comprehensive resident-specific care plan with interventions for R5 pertaining to the implementation of rolled washcloth for the left hand, pillow to elevate left arm and hand for edema management, or a pillow/wedge under sheet to left side to keep arm from falling off bed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #41: Review of an admission Record revealed Resident #41 was a male with pertinent diagnoses which included stroke, muscle weakness, contracture (permanent tightening or stiffening of muscles, tendons, skin leading to limited range of motion and potential deformity) of multiple sites, left elbow, left hand, need for assistance with personal care, bed confinement, paralysis affecting left dominant side, diabetes, and abnormal posture. Review of current Care Plan for Resident #41, revised on 11/20/21, revealed the focus, .(Resident #41) is at risk for skin breakdown r/t (related to) left sided weakness, impaired mobility. with the intervention .CNA (Certified Nursing Assistant) to observe skin integrity during daily cares. Note: Care plan not updated to include the use of the washcloth. Review of Minimum Data Set (MDS) dated [DATE], revealed, .Section GG: Functional Limitation in Range of Motion: Impairment on one side, Upper extremity. In an interview and observation on 1/7/25 at 1:25 PM, Resident #41 was in his room lying in his bed. Resident #41 allowed this writer to observe his left hand as it was under the blanket on his bed. Resident #41's hand was in a loose fist, with no washcloth in his hand. There was a sign on the wall behind the head of his bed which indicated a washcloth should be placed in his left hand very morning. This left hand was under the blanket, and it was in a loose fist, with no washcloth in his hand. Sign on the wall indicated that a washcloth should be placed in his left hand every morning. Resident #41 indicated he couldn't remember if the washcloth was placed in his hand every day but agreed the washcloth was not in place today. During an observation on 01/08/2026 at 9:26 AM, Resident #41 was in his room lying in his bed. head of the bed was approximately 45 degrees. When queried if he had the washcloth in his left hand today, Resident #41 indicated he did not have the washcloth in his hand. In an interview on 1/8/26 at 10:04 AM, Certified Occupational Therapist (COTA) UU reported the hand roll was placed in his hand to keep his hand dry, keep nails from digging in his palm. COTA TT reported the nursing staff were to complete passive range of motion (PROM) with Resident #41. COTA TT reported the communication form was completed and the nursing staff were educated on his care for PROM, ensuring hand hygiene was completed daily as well as a skin check before and after donning of cloth roll and nursing staff signed off on the education sign in sheet they had been educated on the care. COTA UU queried if a sign was still on the wall in his room to remind staff, this writer confirmed the placement of the sign above Resident #41's head of his bed. Review of Occupational Therapy Discharge Summary dated 2/11/25, revealed, .left and roll to be placed during first shift of day.caregivers to completed LUE (left upper extremity) passive range of motion with daily care, sin check daily.

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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 provide care to prevent bowel incontinence for a continent resident in 1 (Resident #31) of 1 resident reviewed for bowel incontinence, resulting in delay of treatment for diarrhea and the potential for dehydration. Findings include:Resident #31: Review of an admission Record revealed Resident #31 was a female with pertinent diagnoses which included disorders of bone density and structure, fall on same level from slipping, tripping, and stumbling, osteoarthritis (degenerative joint disease where protective cartilage wears down causing pain, stiffness, and swelling). This writer observed on 01/06/26 at 1:30 PM, Certified Nursing Assistant (CNA) W report to Licensed Practical Nurse (LPN) S Resident #31 had been having diarrhea with no control of her bowels. In an interview on 01/06/2026 1:48 PM, CNA W reported Resident #31 had not been here long and her bowel movements had not been normal every time she had taken care of her. CNA W reported she had informed the nurse a few days after she had admitted (12/16/25) of the concern with diarrhea, but as far as she was aware nothing had been done for Resident #31. CNA W reported nothing was staying in and almost as soon as Resident #31 had finished eating it was coming right out. CNA W reported she would take her to the restroom and would begin to wash her up and Resident #31 would tell her she needed to sit back down on the toilet. Review of Critical admission Assessment completed on 12/16/25 revealed, Resident #31 was continent of bowel with use of toilet. Review of Orders dated 12/19/25 revealed, .Document BM's Q (every) shift, Every Shift 10:30 PM - 06:30 AM, 06:30 AM - 02:30 PM, 02:30 PM - 10:30 PM.Review of Vitals Report dated 12/7/25 to 1/7/26 revealed, multiple instances of incontinence with loose, liquid stool documented by the CNAs assigned to care for Resident #31. Review of Progress Note dated 12/27/2025 at 09:57 PM, .Resident alert and oriented. Has been continent of bladder, but c/o (complaints of) of not having much sensation and knowing when she has been incontinent of stool. Bed mobility and toileting required 1 assist throughout the day and evening shifts. Lower back pain managed with prn (as needed) Tylenol and repositioning. Appetite 100% for all meals.Vital signs: 97.6-80-16; BP 110/59. Note: There was no documented follow up on this concern. Review of Orders for Resident #31 since admission revealed she was not prescribed any medications to address diarrhea. Review of Progress Notes dated 1/6/26 at 1:52 PM, revealed, .Resident is alert and oriented X 3-4. Resident is able to verbalize needs.Resident is a 1 assist.Resident is continent of urine, incontinent of bowel.No c/o (complaints of) pain or distress noted at this time. Note: this note was entered after LPN S was notified of the concern for continuous diarrhea for Resident #31 from CNA W.Review of medical record for Resident #31 on 1/7/25 following CNA W informing LPN S on 1/6/26 of the concern for diarrhea revealed no orders, no assessments, no progress notes of provider contact to address the concern. In an interview on 1/7/26 at 12:48 PM, Registered Nurse (RN) U reported he would the ask the CNA if the resident had been having the loose stools and would review resident's chart to determine if resident was taking a stool softener, if so, he would place the stool softener on hold due to the condition. RN U reported he would verify if the resident had an anti-diarrheal prescribed as a standing order, if not, he would reach out to the provider to see about adding one, if so, he would reactivate it. RN U reported he would enter a progress note and have staff monitor the resident's bowel movements regularly. In an interview and record review on 1/7/25 at 12:53 PM, Unit Manager (UM) E reported the CNAs have an area in the medical record where they would document their resident's bowel movements under vitals. UM E reported the CNA would notify the nurse if the resident was having loose stool, the nurse would contact the provider to determine if the provider would like to prescribe something to address the diarrhea. UM E reported the nurse would complete a progress note for the resident's condition. UM E reported some residents have standing orders and some don't, for a new resident and a new concern the provider would need to be contacted. UM E reported for a resident who had had diarrhea for a continuous duration, lab work should have been (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted. UM E reviewed Resident #31's medical record and reported there had been no labs completed since Resident #31 had been admitted . UM E reported the concern for Resident #31 should have been added to the doctor's book for the doctor or nurse practitioner to see the resident when in the building. UM E reported the CNAs had been educated they could add a comment for a concern as well as come to the unit managers and notify them of the concernReview of Progress Notes dated 01/07/2026 at 01:31 PM, .Writer (UM E) was informed that resident was having frequent loose stools. Writer spoke with resident about her eating/drinking habits and her bowel habits at home. Resident reported that she drinks coffee with almost every meal. However, she reported that she did not typically drink coffee at home unless someone brought her one when they visited. Writer educated resident on the effects coffee may have on her bowels. Resident stated she didn't know that and would try something different at the next meal. Writer also let resident known that the NP (Nurse Practitioner) was in the facility and writer would inform her of the loose stools she has been having. Writer will update resident with any new orders.Review of Progress Notes dated 01/07/2026 at 02:35 PM, . Writer spoke with NP regarding residents' loose stools. Order received for Imodium 2mg Q (every) 4 hours PRN (as needed) for loose stools. Orders also received to have CBC, CMP, Liver Function Test, TSH (Thyroid), and Lipid (Cholesterol) done on Friday. Order noted and resident notified.

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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 ensure residents were assessed for risk of entrapment and informed consent was obtained prior to installation of bedrails for 1 (Resident #78) of 1 resident reviewed for bed rails, resulting in the risk for entrapment and injury.Findings include:Review of Clinical Guidance for the Assessment and Implementation of Bed Rails, www.fda.gov, 2003, revealed .National surveys of patient death occurring in the bed environment demonstrate the risk of entrapment.when the patient becomes entrapped in the bed rail itself. The population at risk for entrapment are patients who are frail or elderly.or those who have.agitation, confusion.hypoxia (low blood oxygen level).use of bed rails should be based on patients' assessed medical needs and should be documented clearly and approved by the interdisciplinary team.any decision regarding bed rail use.should be made with the framework of an individual patient assessment.bed rail use.should be accompanied by a care plan that presents clear directions.Resident #78Review of an admission Record revealed Resident #78 was originally admitted to the facility on [DATE] with pertinent diagnoses that included: chronic obstructive pulmonary disease (progressive lung disease resulting in decreased ability to maintain blood oxygen levels) and hallucinations (false sensory perception, making someone see, hear, smell, taste or feel thing that aren't actually there, but seem real).Review of a Minimum Data Set (MDS) assessment for Resident #78 with a reference date of 12/6/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 8/15, which indicated the resident was moderately cognitively impaired. During an observation on 1/6/26 at 12:50pm, Resident #78 slept with her head at the foot of her bed. The resident's feet protruded through the bars of a half-length (approximately 36 inches length) bedrail that was raised and locked in place on her bed.Review of a Care Plan for Resident #78 on 1/6/26 revealed no care plan for use of a bedrail.Review of the Observations section of Resident #78's medical record on 1/6/26 revealed no Interdisciplinary Physical Restraint Assessment related to the use of a bedrail.Review of the Physician Orders for Resident #78 on 1/6/26, revealed no orders for use of a bedrail.During an observation on 1/7/26 at 3:12pm, Resident #78 sat in a recliner in her room. The half-length bedrail remained raised and locked in place on her bed.In an interview, Certified Nursing Assistant (CNA) P reported Resident #78 had used the half-length bedrail for a long time. When further queried, CNA P reported Resident #78's bedrail had been in use for at least a month, based on the fact that she had it prior to moving to her current room.Review of a Census Report revealed Resident #78 moved to her current room on 12/15/25.In an interview on 1/8/26 at 11:20am, Resident #78 reported she did not like the bedrail because she regularly bumped her feet on it.Review of a Bed/Side Rail Use policy with a reference date of 1/25 revealed .if a bed or side rail is used the facility must.assess the resident for risk of entrapment.review the risk and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.Procedure: 1. The IDT Enabler/Physical Restraint Assessment will be completed prior to application.2. The physician will be contacted, an order obtained for the type of enabler or restraint 4. Enabler/Physical Restraint Consent form will be completed.6. Maintenance staff will install according to manufacturer's recommendations.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered per the physician's order for 1(Resident #60) of 1 resident reviewed for significant medication errors, resulting in the potential for adverse effects of the administration of digoxin without checking the resident's pulse and/or administering the medication if below the parameter of <60 beats per minute as outlined in the physician order. Findings include: Review of the [NAME]'s Drug Guide revealed, Digoxin (antiarrhythmic medication)-High Alert Medication: This medication bears a heightened risk of causing significant patient harm when it is used in error .Monitor apical (heartbeat heard at the bottom tip of the heart, located on the left side of the chest, it is a more accurate heart rate measure than peripheral pulses, showing actual heart contractions, with a normal adult rate of 60-100 bpm (beats per minute) pulse for 1 full minute before administering. Withhold dose and notify health care professionals if pulse rate is < (less than) 60 bpm (beats per minute) in an adult. [NAME], [NAME], et al. Digoxin. [NAME]'s Drug Guide, 16th ed., F.A. [NAME] Company, 2019. Nursing Central, nursing.unboundmedicine.com/nursingcentral/view/[NAME]-Drug-Guide/51218/all/digoxin.Resident #60: Review of an admission Record revealed Resident #60 was a male with pertinent diagnoses which included congestive heart failure, stroke, mitral valve insufficiency (mitral valve located between the heart's upper and lower left chambers does not close tightly causing blood to leak backward into the left atrium instead of flowing forward), irregular heartbeat, tricuspid valve insufficiency (tricuspid valve between the right atrium and ventricle doesn't close tightly letting blood leak backward), and cardiomyopathy (disease of the heart muscle that makes it harder to pump blood, causing the heart to become enlarged, thickened, or stiff).Review of Resident #60's Orders dated 5/24/23, revealed, .Digoxin tablet, 125 mcg (microgram) (0.125mg); once a day upon rising; AFIB (atrial fibrillation). Hold if APICAL PULSE IS <60. Review of Resident #60's Medication Administration Record (MAR) for 12/8/25 to 1/7/26 revealed, .Digoxin tablet was administered on 12/17/25, pulse was 53; 12/23/25, pulse was 58; 12/30/25, pulse was 58, 12/31/25, pulse was 52; 1/7/25, pulse was 54. Review of Resident #60's Medication Administration Record (MAR) for 11/1/25 to 11/30/25 revealed, .Digoxin tablet was administered on 11/13/25, pulse was 56; 11/26/25, no pulse rate was noted.In an interview on 1/8/26 at 11:45 AM, Director of Nursing (DON) B reported Digoxin was for arrythmia, the nurse would check the pulse prior to giving as if it was not taken it could happen to cause the pulse to lower which would cause death in extreme cases or become unresponsive. DON B reported the therapeutic level should be monitored per the lab guidance the BMP and digoxin level every 6 months. DON B reported the Digoxin should not be given if the nurse had not taken the pulse, and if the pulse was below 60 it should be held. In an interview on 01/08/2026 at 2:59 PM, Pharmacist EE reported the digoxin level should be checked every 6 months. Resident #60 last had his done on 6/20/25. Pharmacist EE reported the digoxin was checked to ensure it was not at a toxic level, and the lab test would be done more frequently for residents who had history of higher levels of digoxin to ensure no toxicity develops.