STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235660	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Woodfield	5370 E Baldwin Road Grand Blanc, MI 48439

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on interview and record review the facility failed to develop a person-centered, comprehensive care plan for 4 residents (# 8, #28, #45, #47) of 16 residents reviewed. Findings include: Resident #8: Advance Directives A record review of the Face Sheet and Minimum Data Set/MDS assessment indicated Resident #8 was admitted to the facility on [DATE] with diagnoses: history of a stroke, right-sided weakness, dementia, depression, anxiety, peripheral vascular disease and hypertension. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 13/15 and the resident needed assistance with all care. A record review of the electronic medical record revealed Resident #8 wished to be a Full code (meaning full resuscitation if her heart stopped and she quit breathing). The Face sheet was flagged Full Code and the physician orders indicated Full code. The Care Plan for Resident #8 identified the following: Social Aspects: . She has chosen the following advanced directives, Code status, dated 11/1/2018; with Interventions including: Code status as ordered, dated 11/1/2018. The Care Plan did not mention the specific Code status the resident had chosen, Full Code. Resident #28: Advance Directives A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #28 was admitted to the facility on [DATE] with diagnoses: Diabetes, depression, hypothyroidism, hypertension, asthma GERD and chronic pain. The MDS assessment dated [DATE] revealed the resident weighed 94 lbs. and was cognitively intact with a Brief Interview for Mental Status/BIMS score of 15/15. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the electronic medical record indicated the Face sheet was flagged with DNR (do not resuscitate) and there was a physician order for Code status: DNR, dated 2/15/2023. A review of the Care Plans for Resident #28 identified the following: Resident/resident representative have chosen advanced directives, dated 7/28/2020. There was no mention what the resident's preference for Advance directives was. Resident #47: Advance Directives A review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #47 was readmitted to the facility on [DATE] with diagnoses: Spina bifida, heart failure, history of intestinal obstruction, diabetes, history of a stroke with right sided weakness, anxiety, kidney disease, ileostomy and Stage 4 pressure ulcer on coccyx. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and she needed some assistance with all care. A record review of the electronic medical record revealed the Face sheet for Resident #47 said DNR. The Care Plan for Resident #47 identified the following: Social Aspects: Resident has elected for comfort care and has chosen Hospice services, dated 3/11/2025. It did not mention what the resident's Code Status preference was. On 5/07/2025 at 12:37 PM, Social Services staff K was interviewed about the process for obtaining the residents' preferences for Code status and she said nursing staff completed the advance directives assessment form and Social Services ensured they were completed and in the information was in the chart. When asked who created the person-centered Care Plan for the resident, she said either Social Services or the MDS Nurse would complete the Care plan. On 5/07/2025 at 3:56 PM, MDS Coordinator L was interviewed about the residents' Care Plans for their specific preferences for Code Status and she said the Social Services staff completed the Code status Care Plans. 37771 Resident #45: A review of Resident #45's medical record revealed an admission into the facility on [DATE] and readmission on 3/1/25 with diagnoses that included stroke, cognitive communication deficit, hemiplegia and hemiparesis of left non-dominant side and pressure ulcer. Further review of the medical record revealed the Resident was on hospice services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/25 at 1:45 PM, an observation was made of the Resident lying in bed sleeping. An interview was conducted with Family Member S regarding Resident #45's care at the facility. The Family Member reported that she was unaware of the Resident having any wounds but reported that the Resident stays mostly in bed, sleeps a lot and health was declining. The Resident had an air mattress that was set at the highest setting for comfort at 5 and alternating air circulation. There was no data on the air bed controller to indicate directive for staff on the air mattress settings. On 5/8/25 at 11:34 AM, a review of Resident #45's care plan revealed a Category: Skin Integrity. At risk for skin breakdown r/t (related to) need for staff assistance with turning and repositioning with an approach dated 1/18/24 Low Air Loss mattress to bed as ordered. A review of Resident #45's orders revealed no order for an alternating pressure mattress. On 5/8/25 at 1:02 PM, an interview was conducted with the Regional Clinical Coordinator (RCC), Nurse B regarding Resident #45's air mattress that was on the Resident's bed. The care plan with the low air loss mattress and lack of directive for settings for the alternating pressure mattress was reviewed. The RCC indicated that the Resident should be ordered the APM air mattress and care planned for the APM air mattress. The RCC was unsure of where the settings for the air mattress could be found by staff and indicated that the settings were set to Resident comfort.

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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** 49944 Based on observation, interview and record review the facility failed to ensure that residents received timely Activities of Daily Living (ADL) care and ensure that residents' preferences were followed for bathing for three residents (R24, R28, R55) of four residents reviewed for ADL care, resulting in residents receiving bed baths instead of showers, not receiving showers on scheduled days, long nails and long facial hair. Findings include: Resident #24 R24 is [AGE] years old and recently admitted to the facility on [DATE] with diagnoses that include cellulitis of the right and left lower leg, diabetes and osteomyelitis. R24 has a brief interview for mental status (BIMS) score of 15, indicating they are cognitively intact. On 05/06/25 at 10:42AM, R24 was asked if they received their showers on time. R24 stated they don't get their showers regularly and often times they get a bed bath. R24 was asked if they prefer a shower over a bed bath and they replied yes. R24 was noted to have a greasy appearance to their hair. On 05/07/25 at 01:41PM, record review revealed that R24 had a shower on 5/2/25(Friday), 4/26/25(Saturday) and 4/21/25(Monday). On 4/25/25 and 5/5/25, both scheduled shower days, no bathing was recorded. On 4/28/25, a scheduled shower day, a partial bed bath was recorded. All bathing recorded outside of scheduled days, was recorded as a partial bed bath. On 05/07/25 at 01:50PM, record review revealed an order for showers every Monday and Friday. Record review revealed a care plan titled Profile Care Guide contained an approach for showers, twice weekly and as needed/requested. On 05/07/25 at 02:10PM, an interview was conducted with certified nursing assistant (CNA) D. CNA D was asked if they have provided care for R24. CNA D stated they have helped R24 with showering. CNA D was asked if R24 has ever refused a shower. CNA D stated that R24 has not refused to take a shower for them. CNA D stated the CNA's are providing showers for the residents they are taking care of. I always try to get my residents to take a full shower. The only time I would give a bed bath is if they refused a shower. CNA D was asked if they knew the difference between a bed bath and a partial bed bath. CNA D stated they weren't sure, but they think that during a partial bed bath everything except the resident's hair gets washed. On 05/07/25 at 03:03PM, R24 was observed sitting in their room watching the television, R24 was noted to have greasy hair. Review of the policy titled, Guidelines for Bathing Preference, revealed: Procedure: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The resident will be advised of Trilogy's guidelines for residents to self-determine their plan of care and schedule during their stay on campus. 2. The resident shall determine their preference for bathing on admission. a. Day of the week. b. Time of day, morning or evening. c. Type of bathing- tub bath, bed bath or shower. 37666 Resident #28: Activities of Daily Living A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #28 was admitted to the facility on [DATE] with diagnoses: Diabetes, depression, hypothyroidism, hypertension, asthma GERD and chronic pain. The MDS assessment dated [DATE] revealed the resident weighed 94 lbs. and was cognitively intact with a Brief Interview for Mental Status/BIMS score of 15/15. On 5/06/2025 at 11:59 AM, Resident #28 was observed sleeping in bed. Her feet were lying outside her blanket and her toenails left and right foot were very long and jagged. Her left toenail was hanging over the end of the left great toe. A review of the physician orders for Resident #28 revealed an order to Clip nails on shower days, Once a day on Wed., Sat. A review of the electronic medical record indicated Resident #28 had received 3 showers from 4/7/2025 to 5/6/2025. A review of the Care Plan for Resident #28 identified the following: Showers/Bathing: Twice weekly per schedule and as needed/requested. Offer/encourage to allow staff to shave facial hair, trim nails, dated 1/5/2023. On 5/7/2025 at 9:00 AM, Resident #28 was observed eating breakfast in bed. Her feet were outside the blanket and her toenails were long and jagged on each foot. The resident was asked if she had recently had her toenails clipped and she said she had not. She said it bothered her to have them clipped. The resident said her feet were bumping the footboard of the bed at times. When asked if she was tall, she said, No, I'm short. Asked her if her toenails were bumping into the bed because they were quite long and she said Maybe. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/08/25 at 2:38 PM, Resident #28 was observed in her bed, awake, talkative and had a visitor. The Assistant Director of Nursing/ADON C and Corporate Nurse B were present also and observed the resident's toenails were very long and jagged. The resident was asked about having her toenails clipped and she said she had a bad experience with toenail clipping sometime in her life and was afraid. Corporate Nurse B said she thought the Wound nurse last trimmed the resident's nails and that it went well. She said she would arrange for someone to clip the resident's nails; the resident was again complaining of her feet touching the foot board of the bed. Corporate Nurse B and the ADON C assisted the resident with repositioning up in bed. 22348 Resident #55 (R55): Activities of Daily Living During the initial tour, R55 on 5/6/25 at 12:30 PM was observed talking to his son in his room. R55 expressed that he would love to have a shower soon. He has not received a shower since being admitted to the facility. And during his 2-week stay at the hospital before coming to the facility on [DATE]. When asked if he was given a bed bath, R55 emphasized that he would prefer a shower in the shower room with water sprinkling on his head instead of a bed bath. A review of R55 Electronic Medical Record was [AGE] years old, admitted to the facility on [DATE] with the diagnosis of Acute Renal Failure, Non-ST Elevation (NSTEMI) Myocardial Infarction, Stage 4 Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, and Dementia (unspecified) in addition to other Diagnoses. Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) Score of 15/15. A score of 15 means R55 is cognitively intact. R55's Care Plan indicated that the plan was to be discharged home after the rehab program. R55 required assistance with Activities of Daily Living (ADLs). R55's care plan indicated for Showers: Twice weekly per schedule and as needed/requested. Regarding transfers, R55's care plan dated 4/26/25 revealed that it requires one person to assist with transfers and may walk with a front-wheeled walker in the room and facility with one person's assistance. Walking/Mobility devices: Wheelchair. On 5/6/25 at 3:45 PM, the Administrator printed R55's Point of Care History showing the following: 4/30/25 at 12:58 PM Shower was signed off as given. 5/1/2025 at 9:49 AM Partial Bed Bath signed off as given. 5/5/2025 at 12:46 PM Partial Bed Bath signed off as given. 5/6/2025 at 8:48 AM Partial Bed Bath signed off as given. On 05/06/25 at 2:42 PM, A review of the shower schedule revealed that R55 is scheduled on Wednesday and Saturday. R55 and son both reported that no showers were received as noted above. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 3:45 PM, R55 said he preferred water spraying on him like a regular shower. R55 thought the permacath (was pointing at the port) dressing was an issue, but he had a shower today for the first time. He said, It felt good. He indicated that he received bed baths but preferred a real shower. On 5/7/2025 at 2:50 PM, R55 was observed with facial hair growth all over. The surveyor asked if he preferred to grow his beard. He said no. He shaves every other day at home. He needed his shaver from home and did not think they would shave him at the facility. No one offered to shave him. R55 commented that since it had gotten long, he now thinks he needs an electric shaver. R55 was asked if he received three bed baths (5/1/25, 5/5/25, and 5/6/25) and one shower on 4/30/25 during your stay? R55 stated, No, I did not get any shower in the shower room. I only received bed baths, but can't recall the dates specifically. R55 was very excited to report that he finally received a shower today.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure that hospice records/communication were part of the medical record for two Residents (#45 and #47) of two reviewed for hospice services. Findings include: Resident #45: A review of Resident #45's medical record revealed an admission into the facility on [DATE] and readmission on 3/1/25 with diagnoses that included stroke, cognitive communication deficit, hemiplegia and hemiparesis of left non-dominant side and pressure ulcer. Further review of the medical record revealed the Resident was on hospice services. On 5/6/25 at 1:45 PM, an observation was made of the Resident lying in bed sleeping. An interview was conducted with Family Member S regarding Resident #45's care at the facility. The Family Member reported the Resident had a couple strokes and his left side was affected. The Family Member indicated the Resident had started on Hospice services about a month ago. On 5/8/25 at 11:16 AM, a review of Resident #45's medical record revealed a lack of Hospice communication, progress notes from hospice, what hospice services visited the Resident, or what care was provided during visits. On 5/8/25 at 12:08 PM, an interview was conducted with the Assistant Director of Nursing (ADON) C regarding hospice communication documentation of hospice service visits. At the Nurses' Station, an observation was conducted with the ADON of the hospice folder for Resident #45. The folder had information about the hospice service and a care plan but lacked documentation of visits or care provided when hospice team members visited Resident #45. When questioned about hospice communication with the facility, the ADON reported that hospice information can be accessed through the portal so that Social Work staff can access the portal. When asked that no other staff can access the portal, the ADON stated, Right, just the social worker. 37666 Resident #47: Hospice and End of Life On 5/6/2025 at 11:14 AM, Resident #47 was observed sitting in a wheelchair in her room. She said she received Hospice services twice a week from a Hospice Nurse and Hospice Nurse Aide. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #47 was readmitted to the facility on [DATE] with diagnoses: Spina bifida, heart failure, history of intestinal obstruction, diabetes, history of a stroke with right sided weakness, anxiety, kidney disease, ileostomy and Stage 4 pressure ulcer on coccyx. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and she needed some assistance with all care. On 5/8/2025 at 9:00 AM, a nurse on the 200 Hall was asked if Resident #47 had a Hospice chart and she said the resident did have a Hospice chart. The nurse began looking through binders at the nurses' desk and said she could not locate the Resident's Hospice chart. A review of the electronic medical records/emr documents, progress notes other tabs, did not reveal any Hospice Notes. On 5/6/2025 at 9: 15 AM, the Administrator was asked if Resident #47 had a Hospice chart, and she said she would locate it. On 5/08/2025 at 9:56 AM, the facility provided a hard binder with several documents from the Hospice company in it for Resident #47, but there were no Hospice Nurse or Hospice Aide visit notes. This was reviewed with the Administrator, she said the notes are in the emr. Reviewed they were not located in the emr. On 5/8/2025 at 11:30 AM, the facility provided a binder with Hospice notes, including Nurse and Nurse Aide visit notes. Each document was printed with the date 5/8/2025. The Hospice note visit dates were from 3/11/2025 to 5/7/2025. On 5/08/2025 at 12:04 PM interviewed The Assistant Director of Nursing/ADON was interviewed about the Hospice Binder- all of the notes were printed 5/8/2025. They were not in the medical record. Reviewed on initial tour, the resident had voiced that she was struggling with staff not providing care like she did at home, she said she had talked to Hospice about it related to ileostomy care and wound care.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on interview and record review, the facility failed to ensure that weights were obtained, monitored as ordered, and recommended for 2 residents (#28 and #55) of three residents reviewed for nutrition. Findings Include: Resident #28: Nutrition A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #28 was admitted to the facility on [DATE] with diagnoses: Diabetes, depression, hypothyroidism, hypertension, asthma GERD and chronic pain. The MDS assessment dated [DATE] revealed the resident weighed 94 lbs. and was cognitively intact with a Brief Interview for Mental Status/BIMS score of 15/15. On 5/7/2025 at 1:15 PM, during an interview with Resident #28 she was observed sitting in bed eating her lunch. She appeared very thin. A record review of the electronic medical record/emr weights for Resident #28 identified the following weights: 1/12/2025 98.9 lbs. 2/19/2025 94.2 lbs. 3/2/2025 88 lbs. (flagged in red print) 3/12/2025 93.6 lbs. 3/26/2025 93.4 lbs. 4/15/2025 95.2 lbs. A review of the physician orders for Resident #28 revealed Order Set WT- Monthly Weight, Once a Day on the 5th of the Month, 6:00 AM- 10:00 PM, start date 6/25/2024. Resident #28's weights were obtained inconsistently; the resident lost 6.2 lbs. from 2/19/2025 to 3/2/2025 and 10 lbs. from 1/12/2025 to 3/2/2025. The weights were obtained by the 5th of the month as ordered one time (3/2/2025). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/07/2025 at 1:29 PM, during an interview with Registered Dietitian/RD J, she said the staff weigh the residents and she reviews the weights weekly when she is in the facility. RD J said the electronic medical record/emr weight program, flags out of range weights. Reviewed Resident #28 had red weights with one weight of 88 lbs. on 3/2/2025. The resident was reweighed 10 days later. The RD said she had documented an assessment on 3/3/2025 and there was a dietary recommendation related to significant weight loss. The RD recommended weekly weights. The resident did not have weekly weights obtained. On 5/8/2025 at 2:30 PM, Resident #28 was observed sitting up in her bed talking to a visitor. Corporate Nurse B and Assistant Director of Nursing C also entered the room. During conversation with the resident, she mentioned she was upset because she said she was told she weighed 88 lbs. she said she never weighed below 100 lbs. and she was very bothered by this. A review of the facility policy titled, Clinical Services- Weight Monitoring, dated reviewed 12/20/2024 provided, Weight monitoring is essential to the well-being of the residents we serve and requires a multidisciplinary approach . Review of missing weights: a. Monthly; b. Weekly weights as ordered; c. Daily weights as ordered . Review of error weights, daily . Re-weights as needed . Weely review of 5% weight changes . 22348 Resident #55 (R55): Nutrition A review of R55 Electronic Medical Record (EMR) was [AGE] years old, admitted to the facility on [DATE] with the diagnosis of Acute on Chronic systolic (congestive) heart failure CHF, Acute Kidney Failure, Non-ST Elevation (NSTEMI) Myocardial Infarction, Stage 4 Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, and Dementia (unspecified) in addition to other Diagnoses. R55 requires Hemodialysis three times a week on Tuesdays, Thursdays, and Saturdays. R55's Minimum Data Set (MDS) Assessment, dated May 1, 2025, revealed a Brief Interview of Mental Status (BIMS) Score of 15/15. A score of 15 means R55 is cognitively intact. R55's Care Plan indicated that the plan would be discharged home after the rehab program. R55 required assistance with Activities of Daily Living (ADLs). R55's goals for weight monitoring care plan indicated: 1) No further unwarranted significant weight gain will occur, 2). Meet Nutritional Needs and maintain appropriate weight and labs for dialysis. Approach: Obtain weight as ordered. A Physician's Order was noted for: Daily Weight Special Instructions: DX: CHF Once A Day 06:00 AM - 10:00 PM Date order started: 4/27/2025 and end date: 5/26/2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R55's Vitals and Weights Recorded were the following: 05/07/2025 04:21 PM Weight: 164.2 lbs / Routine BMI: 24.25 05/06/2025 10:07 AM Weight: 169 lbs / Routine BMI: 24.95 05/05/2025 09:56 AM Weight: 164.8 lbs / Routine BMI: 24.33 05/04/2025 10:30 AM Weight: 165.4 lbs / Routine BMI: 24.42 05/03/2025 - - *No Entry Found 05/02/2025 10:04 AM Weight: 161.8 lbs / Routine BMI: 23.89 05/01/2025 11:58 AM Weight: 161.6 lbs / Routine BMI: 23.86 04/30/2025 03:44 PM Weight: 164 lbs / Routine BMI: 24.22 04/29/2025 - - *No Entry Found 04/28/2025 - - *No Entry Found 04/27/2025 12:00 PM Weight: 159.8 lbs / Admission BMI: 23.6 04/26/2025 06:58 PM Weight: 154.6 lbs / Admission BMI: 22.83 Review of the nurse's notes did not reflect any weights recorded on the days missing 4/28/25, 4/29/25, and 5/3/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235660	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Woodfield	5370 E Baldwin Road Grand Blanc, MI 48439

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 The facility failed to inform and offer transportation to and from dialysis appointments, as part of the services at no cost, for one resident (R#55), of 2 residents reviewed for dialysis services. Findings include: Resident #55 (R55): Dialysis R55 was [AGE] years old, admitted to the facility on [DATE] with the diagnosis of Acute Renal Failure, Non-ST Elevation (NSTEMI) Myocardial Infarction, Stage 4 Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, and Dementia (unspecified) in addition to other Diagnoses. Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) Score of 15/15. A score of 15 means R55 is cognitively intact. R55's Care Plan indicated that the plan was to discharge home after the rehab program. He was scheduled for dialysis every Tuesday, Thursday, and Saturday. R55's CarePlan indicated a coordinated care with dialysis transported by the family. R55 on 5/6/25 at 12:30 PM was observed in his room talking to his son while waiting for the second son to arrive. It was R55's second son's turn to drive R55 to dialysis before the 1:30 PM appointment. Son #1 was there as backup to ensure he made it on time. While waiting, R55 expressed that he would love to have a shower soon. He has not received a shower since he was at the facility, and he did not receive a shower while admitted at the hospital for 2 weeks. R55 stated he would prefer a shower in the shower room with water sprinkling on his head instead of a bed bath. On 05/06/25 at 12:32 PM, R55's son was concerned about why the facility did not provide transportation for his father's dialysis appointment. His brothers and he have to arrange and ensure that R55 is transported to and from dialysis 3 times a week. R55's son asked why other facilities have a transport service and not this one. The hospital, before discharge, made sure that we agreed to transport our dad to dialysis before we were accepted to this facility. If we were offered a choice, we would have used their transportation. No one discussed this service, and the facility did not provide it. Otherwise, we would have chosen to use their transport services. R55's dialysis documentation record and nursing notes were reviewed in R55's: Tuesday, 4/29/25 Monday, 5/1/25 Saturday, 5/3/25 Tuesday, 5/6/25 Although the nurses' notes indicated that R55 went to dialysis on all four days, a missing dialysis visit documentation for May 3, 2025, was noted. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/25 at 10:58 AM, Licensed Practical Nurse (LPN) AW stated that Resident (#55) left at 9:30 for dialysis today. She indicated that it was the family's choice to transport R55. Our transportation Service is free of charge if the family prefers to use it. The Social Services Director #1 in an interview on 5/7/25 at 02:34 PM, revealed that transportation related to dialysis was part of the bundled payment, which means they are included in the services with no extra fees. We provide transportation to and from the dialysis center and don't require the family to find the transportation. When asked who makes that conversation with the family, Social Services Director #1 was not sure who does but explained the bundled payment protocol that Medicare and Managed Care insurances have the transportation included as services. On 5/8/25 at 2:49 PM, a conversation with the Administrator and the Administrator in Training (AIT) was conducted regarding R55 dialysis transport. The Administrator confirmed that everything related to dialysis, including transportation, should be covered with no extra charge. The Administrator was unaware that it was not the family's choice to drive R55 to and from dialysis. She was unaware of the issue. There should have been a conversation upon admission that did not happen. The Administrator admitted that they assumed it was the family's choice upon admission. The Administrator did not know what was said at the hospital before transfer. It should have been explained to the family that the facility can transport dialysis. The Guidelines for Dialysis dated 5/11/16 were reviewed on 5/8/25 at 12:00 PM. Purpose Statement: The purpose of this policy is to provide communication to Dialysis Providers and monitoring of residents receiving dialysis. Policy: Guidelines for Dialysis Procedure: 1. The campus shall have the information regarding the Dialysis Provider schedule and requirements such as but not limited to: a. Location, b. Date and time of service to be provided. c. Required documentation from campus. 2. The campus shall be responsible for arranging or providing transportation to and from the Dialysis Provider .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure safe and secure medication storage and ensure that supplies was labeled and not expired for two medication rooms and four medication storage carts and treatment carts reviewed for storage of drugs, biologicals and supplies. Findings include: On [DATE] at 2:32 PM, an observation was made with Nurse G of the 200 Hall medication storage room. An observation was made of Assure Prism glucose control solutions, two boxes with one box open and the other box sealed, both boxes expired on [DATE]. There was not an open date on the control solution bottles or on the box. The medication room was reviewed for other, not expired control solutions but there were none found in the medication room. When asked, Nurse G indicated they should be dated when opened. A review of the med cart ,d+[DATE] was conducted with Nurse G. The Nurse was asked if there was the glucose control solution in the medication cart, but it was not found. The Nurse asked the other nurse if there was any in the other 200 Hall medication cart and the Nurse indicated there was none. An observation was made of the medication cart for the 215 to 223 rooms. There were medications in bubble packaging that the Nurse indicated appeared to be from back up. There was no name or room number to identify whose medications they were. The Nurse indicated they should be labeled and stated, It could be from back up, but I don't know who they belong to. The medication was two tablets of memantine, a metoprolol tartrate, and atorvastatin. When asked if the medication is not used what do you do with them, the Nurse stated, I would use it because it's been already signed out for the resident. On [DATE] at 3:30 pm, an observation was made with Nurse R of the 300 Hall medication room with the treatment cart in the room. An observation was made of a betadine solution opened, without an open date, and had a white powder residual on the outside of the bottle. The Nurse was asked what it was but was unsure what the white powder residue was and reported it could be nystatin powder. The Nurse reported that it should be dated when it was opened. A heel protective dressing was opened and laying in the drawer. The Nurse removed it and stated, It's been opened. Three triad hydrophilic wound dressing were opened and not dated. When asked when they were opened, the Nurse stated, I don't know, they should be dated. When asked for glucose control solutions, the Nurse was unable to find any in the medication room or the 300 medication cart. A review of the medication cart revealed glucose test strips opened and not dated with an open date. When asked about facility policy of dating the glucose test strips when opened, the Nurse reported the vial should be dated when opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:10 PM, an interview was conducted with Regional Clinical Coordinator RCC, Nurse B regarding glucose monitoring solutions. At 4:14 PM, Central Supply Staff Q looked for the test solution for the glucometers but was unable to find any except for the expired control solutions found earlier. The RCC was asked about calibration of the glucose monitors. The RCC reported that the machines are not calibrated unless they were getting an error or as needed and reported that they should have some solution available. On [DATE] at 10:30 AM, an observation was made during medication administration with Nurse H on the 200 hall unit. There were two medication carts and a treatment cart that was positioned near the nurse's station. Upon return to the nursing station area after observing Nurse H performing medication administration, an observation was made of keys on the treatment cart that were on the top of the cart on a pole. The Nurse was asked what the keys were for, and the Nurse explained they were the keys to open the treatment cart. The Nurse was asked if that was where the keys were normally kept. The Nurse reported that the keys are usually with the cart and sometimes they put them on the side of the cart. An observation was made of the keys visible on the top of the cart. The Nurse indicated that due to having only one set of keys, both nurses need to access the cart, and the keys were left with the cart for the two nurses. A review of the contents of the treatment cart revealed multiple treatments in the cart that were prescription medications. The items included Bio Freeze, antifungal treatments, ammonia lactate, arthritic pain gel, Lotrimin, zinc oxide ointments, Triamcinolone acetonide cream, Nystatin powder, and triple antibiotic ointment. Other items in the cart included wound dressings, wound cleansers, wound/treatment supplies and needles. On [DATE] at 11:04 AM, an interview was conducted with the Director of Nursing (DON) regarding the storage of the treatment cart keys on the top of the cart. The DON indicated that they were made aware of the keys left on the treatment cart and reported they were going to have another set of keys made so each nurse will have access to the treatment cart with their medication cart keys that they keep with them. 37666 FACILITY Medication Storage and Labeling On [DATE] at 2:00 PM, Nurse Aide E was overheard and observed asking Nurse H for the keys to enter the medication room that was located behind the nurse's desk. Nurse Aide E said he wanted to get an ice pack. Nurse H was observe standing in the hallway and tossing Nurse Aide E her keys to the medication room. Nurse Aide E was observed opening the door to the medication room and he went in by himself. Nurse H was asked if Nurse Aides were allowed to go into the medication room unattended and she said they were allowed to go in to get an ice pack. The Surveyor and Nurse H entered the medication room and Nurse Aide E was observed taking an ice pack from the medication freezer. The medication refrigerator had a location for a lock on it, but it was not in place; it was unlocked. Inside the refrigerator there were a variety of medications, including insulin pens and vaccinations. They were not in a locked area. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:10 PM, upon exiting the medication room with Nurse H and Nurse Aide E, Nurse G approached the nurses' desk and Nurse H handed her a set of keys to the medication cart and medication room, as Nurse G had been on break. Nurse G was asked if Nurse Aides were allowed to go into the medication room on their own and she said they go in to get ice packs. On [DATE] at 2:33 PM, during an interview with Nurse Supervisor I, she was asked if Nurse Aides were allowed to go into the medication room and she stated, Only if they are with a nurse.