STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235661	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonegate Health Campus	2525 Demille Road Lapeer, MI 48446

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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 who consume food from the kitchen.Findings include:On 02/09/2026 at 9:45am-10:33am during the initial kitchen tour with Director of Food Services A, observed the meat slicer visibly soiled with crumbs accumulating on surface, stored in the dry storage room in the kitchen. During this observation, Director of Food Services A was interviewed on how often the meat slicer is used and answered it's used about twice a year and it's cleaned before use. On 02/09/2026 at 9:45am-10:33am observed dust accumulation on metal lids stored on a rack near the handwashing sink, located in the kitchen. On 02/09/2026 at 9:45am-10:33am observed the can opener visibly soiled. During this observation, [NAME] B was interviewed on how often the can opener is cleaned and stated it's cleaned every night. On 02/09/2026 at 9:45am-10:33am observed the mixer visibly soiled with black and yellow residue. During this observation, Director of Food Services A was interviewed on how often the mixer is cleaned and she stated it's cleaned every time it's used. On 02/09/2026 at 10:33am observed built up residue on the surface near the nozzles of the juice machine in the dining area near the kitchen. During this observation, Director of Food Services A was asked how often the juice machine surfaces are cleaned and she stated the nozzles are cleaned on a rotation and the backsplash surface is wiped down daily. On 02/09/2026 at 10:35am observed accumulated residue on the nozzles of the Folgers coffee machine in the cafe kitchenette. During this observation, Director of Food Services A was asked how often the nozzles are cleaned and she stated it's cleaned on a rotation. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.On 02/09/2026 at 11:05am-11:55am during lunch observation, observed macaroni pasta salad was sitting on ice at the food prep line and was temped at 49 F using Thermapen. During this observation, Director of Food Services A was asked what temperature the pasta salad should be cold holding, and stated she wasn't sure. On 02/09/2026 at 11:05am-11:55am observed mechanical pasta salad in a tub without ice on the food prep line and it was temped at 52 F using Thermapen. According to the 2022 Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control, time/temperature control for safety food shall be maintained: .at 5 C (41 F) or less. According to the facility's policy on hot and cold holding, Cold foods should be 40 degrees or less when the temperature is taken in the kitchen at the time of service. On 02/09/2026 at 11:49am observed [NAME] D battering raw fish with one gloved hand, then removed the soiled glove with their other gloved hand and then proceeded to put fries onto a plate with the same gloved hand. According to the 2022 FDA Food Code, 3-304.15 Gloves, Use Limitation .If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions (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	occur in the operation. On 02/10/2026 at 11:20am fried shrimp on the steam table was temped at 127 F and 124 F using Thermapen. During this observation, Director of Food Services A was asked what the hot holding temperature is for the fried shrimp, and she stated it's usually around 160 F. The fried shrimp was temped again by Director of Food Services A and it was 114 F. According to the 2022 FDA Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control . time/temperature control for safety food shall be maintained .at 57 C (135 F) or above. According to the facility's hot and cold holding policy, Hot food in the steam table should be at least 135 or higher degrees Fahrenheit and arrive approximately at greater than or equal to 120 degrees Fahrenheit when the resident is served.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed timely for six residents (R5, R6, R8, R17, R64, R84) of seven residents reviewed for MDS assessments. Findings include:Resident #5: R5 is [AGE] years old and most recently admitted to the facility on [DATE] with diagnoses that include chronic kidney disease, chronic respiratory failure, dependence on renal dialysis and diabetes mellitus. On 02/10/2026, record review of the Minimum Data Set (MDS) assessments in the electronic medical record (EMR) revealed an MDS Quarterly assessment that was opened on 01/06/26 and closed on 01/26/26. Resident #6: R6 admitted to the facility on [DATE] with diagnoses that include coronary artery disease, hypertension and traumatic brain dysfunction. R6 has a brief interview for mental status (BIMS) score of 14, indicating they are cognitively intact. On 02/10/2026, record review of the Minimum Data Set (MDS) assessments in the electronic medical record (EMR) revealed an MDS Quarterly assessment that was opened on 01/05/26 and closed on 01/26/26. The assessment was completed seven days late. Resident #8: R8 admitted to the facility on [DATE] with diagnoses that include stroke, hemiplegia, anxiety and depression. R8 has a BIMS score of 15, indicating they are cognitively intact. On 02/10/2026, record review of the Minimum Data Set (MDS) assessments in the electronic medical record (EMR) revealed an MDS Quarterly assessment that was opened on 01/02/26 and closed on 01/26/26. The assessment was completed 10 days late. Resident #17: R17 admitted to the facility on [DATE] with diagnoses that include chronic kidney disease, anemia, stroke and epilepsy. On 02/10/2026, record review of the Minimum Data Set (MDS) assessments in the electronic medical record (EMR) revealed an MDS Quarterly assessment that was opened on 01/06/26 and closed on 01/26/26. The assessment was completed six days late. Resident #64: R64 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include atrial fibrillation, hypothyroidism, anemia and acute kidney failure. On 02/10/2026, record review of the Minimum Data Set (MDS) assessments in the electronic medical record (EMR) revealed an MDS Quarterly assessment that was opened on 12/22/25 and closed on 01/26/26. The assessment was completed 21 days late. Resident #84: R84 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include diabetes mellitus, repeated falls, cognitive communication deficit and hyperlipidemia. On 02/10/2026, record review of the Minimum Data Set (MDS) assessments in the electronic medical record (EMR) revealed an MDS Quarterly assessment that was opened on 01/02/26 and closed on 01/26/26. The assessment was completed 10 days late. On 02/10/2026 at 12:46PM, an interview was conducted with Minimum Data Set (MDS) Coordinator F, MDS F was asked how many days you get to complete a quarterly assessment. MDS F stated, we get 14 days from the assessment reference date (ARD) to complete the assessment. MDS F was asked to review a quarterly MDS assessment for R17. MDS F was asked if the quarterly assessment is considered late since it was completed on 01/26/26. MDS F stated, yes, it is late. MDS F was provided a list of seven residents who had late assessment and asked to provide the information on when the assessment was started and when it was completed. MDS F provided the requested information, six of the seven residents had late MDS quarterly assessments. On 2/10/26 at12:56PM an interview was conducted with Corporate MDS Support G: Corporate G was asked why these assessments were completed late. Corporate G stated the unfinished areas of the quarterly assessments are the social services section. We have been down to one social worker since December, and we were down to one prior to our newest Social Worker coming on. The social worker who recently left us most recently left on 01/16/26. Corporate G' was asked if they were aware there was a problem with MDS assessments being completed on time. Corporate G stated, yes, we were aware that we were late completing the social services sections of the MDS assessments. Corporate G was asked if this information was being taken to Quality (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assurance (QA) to put a plan in place to correct it. Corporate G stated, no, but we probably should of. On 02/10/2026 at 1:13PM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA was asked about the late MDS assessments and why they were late. The NHA stated we have had 1.5 MDS nurses in the facility recently and we have been approved for another full time MDS nurse. However, we have had trouble hiring a second person as of now. The NHA was asked if they were aware that these assessments were late. The NHA stated, yes, the corporate nurse and I identified this, and we have been looking into MDS completion. I gave the MDS Coordinator a discipline for not completing the MDS timely. So, yes, I was aware that this was an issue. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, revealed that Quarterly MDS Assessments are to be completed 14 days from the ARD.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary practices were followed for respiratory equipment including changing/dating oxygen tubing and humidification canisters for four residents (R5, R7, R19 and R81) and the storage of a nebulizer treatment chamber and mouthpiece for one resident (R5) of five residents reviewed for respiratory care. Findings include:R19:According to a review of R19's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to medical diagnoses of chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), permanent atrial fibulation (AFIB/ irregular heart rhythm), diabetes mellitis type II (DM), and congestive heart failure (CHF). R19's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) assessment score of 12/15 that indicated moderate cognitive impairment.On 02/09/2026 at 10:20AM, During an observation of R19 she was resting in bed, wearing oxygen (O2) via nasal cannula (NC) on 3 liters (L), the O2 tubing and humidification canister had no date of initiation identified.On 02/11/2026 at 8:20AM, During an interview with ICP nurse H she was asked about respiratory equipment use and storage. When she was asked about the procedure for changing of O2 tubing and humidification canisters the ICP nurse H said that the O2 tubing is changed two times a month and is done on night shift, she further said that the humidification chamber is changed at the same time. ICP nurse H said they are dated and initialed each time they are changed. ICP nurse H indicated she did monthly rounds in which this was an included item on the check off list and provided logs from November, December and January and said she had not completed rounds for February, so it had not been completed. ICP nurse H indicated that the nurses that worked on the floor changed the tubing and canisters and that she monitored it monthly.On 02/11/2026 at 10:00AM, An observation of R19 was made, she was resting in her bed watching television, wearing oxygen (O2) via nasal cannula (NC) on 3 liters (L), the O2 tubing and humidification canister had no date of initiation identified.On 02/11/2026 at 11:00AM, During a follow up interview with ICP nurse H she clarified that the respiratory equipment policy said O2 tubing was changed monthly. When ICP nurse H was queried about the humidification canisters, she replied they were to be changed when the O2 tubing was changed. ICP nurse H confirmed that they both were to be dated and initialed when changed.A record review of R19's care plan revealed: Problem: Resident has potential for complications; functional and cognitive status decline related to respiratory disease R/T: COPD. Approach: Administer oxygen per MD order and as needed.R5:According to a review of R5's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to diagnoses of hypertensive CKD stage 5 (end stage kidney failure requiring dialysis), chronic obstructive pulmonary disease (COPD), atrial fibulation (AFIB/ irregular heart rhythm), diabetes mellitis type II (DM), Anemia (low blood count). R5's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) assessment score of 11/15 indicated moderate cognitive impairment.On 02/09/2026 at 1:30 PM, During an observation of R5, he was sitting up in his wheelchair in his room. R5 was wearing O2 via NC set at 2.5L, the O2 tubing had no date of initiation identified. The humidification canister was dated 01/09.On 02/10/2026 at 8:40 AM, During an observation of R5, he was resting in bed, in his room watching tv. R5 was wearing O2 via NC set at 6L, the O2 tubing had no date of initiation identified. The humidification canister was dated 01/09. R5's nebulizer medication chamber was observed on the bed side chair with the mouthpiece rested on a pair of black shoes (that were also on the chair), next to a red stuffed 'hermit crab' that R5 said his grandson had brought him when he visited, there was a hand grabber tool laid on top of all of that a crossed the seat of the chair. On 02/11/2026 at ~(approximately)10:00 AM, R5 was not present in his room and observation of R5's room revealed O2 tubing that had no date of initiation identified. The humidification canister was dated 01/09.A record review of R5's orders revealed:Dated 08/04/2025: Order Set O2- Change oxygen tubing monthly. Once A Day on the 1st of the MonthDated 02/06/2026: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg (2.5 mg base)/3 mL; amt: 1 treatment; inhalation Special Instructions: for SOB Three Times A Day 06:00 AM - 10:00 AM, 11:00 AM - 01:00 PM,06:00 PM - 10:00 PM.Dated 08/04/2025: Mask and tubing should be cleaned weekly with soapy water and rinsed. Air dry and place mask in clean setup bag. Once A Day on Mon 06:00 AM - 02:00 PM.R7:According to a review of R7's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to diagnoses of Acute post hemorrhagic anemia (blood loss and low blood count), chronic obstructive pulmonary disease (COPD), chronic respiratory failure, atrial fibulation (AFIB/ irregular heart rhythm), and diabetes mellitis type II (DM). R7's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) assessment score of 10/15 indicated resident had moderate cognitive impairment.On 02/09/2026 at 10:47 AM, During an observation of R7, she was resting in bed and had on O2 via NC set at 2L, the O2 tubing had a label that said 121 and the humidification canister had no date of initiation identified.On 02/10/2026 at 08:22 AM, During an observation of R7, she was resting in bed and had on O2 via NC set at 2L, the O2 tubing was dated 2/10 at 2 PM and humidification canister had no date.On 02/11/2026 at 09:32 AM, During an observation walk through of R7's room with ICP nurse H R7's humidification canister had no date.A record review of R5's orders revealed: Dated 02/04/2026: Order Set O2- Change oxygen tubing monthly. Once A Day on the 1st of the Month 10:00 PM - 06:00 AMR81:According to a review of 81's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to diagnoses of fracture of right acetabulum (hip) with replacement, chronic obstructive pulmonary disease (COPD), chronic obstructive pulmonary disease (COPD), permanent atrial fibulation (AFIB/ irregular heart rhythm), diabetes mellitis type II (DM), congestive heart failure (CHF).diabetes mellitis type II (DM), congestive heart failure (CHF). R81's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) assessment score of 12/15 indicated moderate cognitive impairment.On 02/09/2026 at ~3:30 PM, During an observation of R81, she was sitting up in her wheelchair in her room visiting with her daughter. R81 was wearing O2 via NC set on 2L, the O2 tubing and humidification canister had no date of initiation identified. R81 said she wore her O2 all the time, she had breathing issues especially when lying down.On 02/11/2026 at 8:15AM, During an observation of R81, she was resting in bed she was wearing O2 via NC set on 3L, the O2 tubing and humidification canister had no date of initiation identified.A record review of R81's orders revealed: Dated 01/06/2026: Order Set O2- Change oxygen tubing monthly. Once A Day on the 1st of the Month 10:00 PM - 06:00 AM According to a record review of the facilities standard operating procedure (SOP) titled ?Administration of Oxygen' revealed in ?details: 14. Date the tubing for the date it was initiated. a) Tubing should be changed monthly and PRN (as needed)'.According to a record review of the facilities standard operating procedure (SOP) titled ?Respiratory equipment' revealed in ?details: 2. Oxygen administration. i)Change oxygen cannula and tubing monthly and as necessary. 3. Medication nebulizers/continuous Aerosol. c)After completion of therapy: i) remove nebulizer container. ii) rinse container with fresh tap water. iii) allow to dry on plain paper towel or gauze. iv) reconnect to administration setup. f) store circuit in plastic bag marked with date and residence name in between uses.'According to a record review of the facilities policy titled ?infection prevention and control program' the purpose statement revealed, The purpose of this policy is to: To establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Procedure: 2. The campus shall designate a member of the clinical team to monitor the campus IPCP program to perform surveillance to identify, investigate, control, and prevent the spread of infection and reporting for the IPCP. e. Monitors compliance with infection control practices and procedures.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure comprehensive code status information for one resident (Resident #76,) of four residents reviewed for code status, resulting in a lack of a physician's order for code status for (R76). Findings include: Resident #76 (R76): R76 is [AGE] years old and admitted most recently to the facility on [DATE] with diagnoses that include chronic kidney disease, congestive heart failure, heart disease and dependence on renal dialysis. On 02/10/2026 at 9:11AM, record review of the electronic medical record (EMR) revealed there was no physician order present for code status in the order set. On 02/10/2026 at 3:17PM, an interview was conducted with Social Worker (SW) C. SW C was asked if they are responsible for entering in the orders for code status. SW C stated that the nurses do that and I am responsible for the care plans for code status. On 02/10/2026 at 3:20PM, an interview was conducted with the Director of Nursing (DON). The DON was asked who was responsible for entering the code status orders for residents. The DON stated that the admission nurse does that. They get the signed do not resuscitate (DNR) or full code and enter it in the order set. The DON stated If a resident is a DNR they have to wait for the physician's signature, while waiting for signature the resident would be a full code by default until it is signed. The DON was asked why the code status order was missed for R76. The DON stated, R76 just went to the hospital recently and we had to discontinue all of the orders. But it should have been caught upon admission during the chart review. Review of the policy titled, Guidelines for Advanced Directives, revealed, Procedure: 6. The nursing staff will confirm the desired code status and obtain an order from the physician. Verbal Wishes if witnessed by 2 people will be honored until an order is officially obtained. The DNR form will be completed documenting these desires and scanned into the medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review the facility failed to develop and implement comprehensive care plans for 1 resident (Resident #107) of 22 residents reviewed, resulting in Resident #107 lacking Care Plans for an indwelling urinary catheter and bowel and bladder incontinence related to diarrhea and constipation, which could lead to the resident lacking necessary care and services. Findings Include: Resident #107: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #107 was admitted to the facility on [DATE] with diagnoses: Diabetes, history of a stroke, urinary tract infection, bronchitis, sinusitis, GERD, obstructive and reflex uropathy (bladder dysfunction), hydronephrosis (kidney disease), urinary retention, hypertension and hypothyroidism. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed some assistance with care. In addition, Section H of the MDS assessment Bladder and Bowel indicated the resident had an indwelling catheter and was frequently incontinent of bowel. On 2/09/2026 at 1:32 PM, Resident #107 was observed sitting in her bed. She said she had been having frequent diarrhea and did not know why. She said she had a history of IBS (irritable bowel syndrome) and she used Imodium (anti-diarrheal medication) at home. She said she was not sure what they give her at the facility. Resident #107 said the diarrhea was irritating a wound on her buttocks and she was uncomfortable. The resident was also observed to have an indwelling catheter. The resident said she had a foley catheter since hospitalization, and stated, I don't know why I have it. They said I had a UTI in the hospital and needed it. During a record review of the progress notes the following was identified: 2/10/2026 at 2:01 PM, a progress note from Nurse Practitioner P, . Chief Complaint: Foley catheter malfunction, stat labs, exchange of foley catheter, assessment of sacral wound. last night nursing was having difficulty with resident's catheter, it was exchanged. 2/10/2026 at 3:49 AM, a nursing progress note, Replaced resident foley cath, resident had no output in foley bag since at least 6 pm. Attempted to flush foley, was unable to flush. 2/3/2026 at 5:53 AM, a nursing progress note, Resident is (complaining of) constipation. A review of the Medication Administration Record/MAR and Treatment Administration Record/TAR for February 2026 identified the following: Staff to use enhance barrier precautions, wearing a gown and gloves at minimum during high-contact care activities, Twice a day, Foley (indwelling catheter), start dated 1/30/2026. Verify last BM (Bowel movement) and initiate BM protocol if no BM in last 72 hours, Twice a day, enter size and date of last BM, start date 1/30/2026. A review of the charting for bowel movements on 6:00 AM- 6:00 PM and 6:00 PM - 6:00 AM indicated the resident had days with no BM and some days with several BMs. A record review of the Care Plans for Resident #107 identified the following: Resident experiences episodes of incontinence r/t (related to) decreased mobility--- start date 1/26/2026. There was no mention of bowel or bladder incontinence and there was no mention the resident had episodes of diarrhea and constipation or an indwelling urinary catheter. There were no additional care plans mentioning bowel or bladder for Resident #107. Nurse Practitioner P was interviewed on 2/11/2026 at 12:41 PM, she said she saw Resident #107 on this day. She said the resident told her she had diarrhea and now her bowel medications were on hold. She received MiraLAX as needed, Maalox as needed and Senna twice a day. She said the Resident #107 had just had a dose of Imodium for diarrhea. During the interview with Nurse Practitioner P on 2/11/2026 at 12:45 PM, she said Resident #107 had a history of urinary retention, which was the reason for the urinary catheter. She said the catheter was replaced because no urine was draining. She said a bladder scan showed 500-600 ml urine in bladder and after the catheter was changed, urine flowed. She said the resident had a history of UTI's and hydronephrosis (when the kidneys swell from incomplete bladder emptying). On 2/11/2025 at 3:30 PM, during an interview with the Director of Nursing/DON related to Resident #107 lacking a Care (continued on next page)

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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 - Few	Plan for Bowel and Bladder Continence/Incontinence, diarrhea, constipation and an indwelling urinary catheter. She said she would look into it. A review of the facility policy titled, Comprehensive Care Plan Guideline, dated revised and effective 5/22/2018 provided, Purpose Statement: To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease.

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	235661	A. Building B. Wing	02/11/2026

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide timely vision services for one resident (Resident #17) of two residents reviewed for vision services. Findings include: Resident #17 (R17): R17 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include cataracts, diabetes mellitus and hemiplegia and hemiparesis following cerebral infarction affecting the left side. On [DATE] at 1:07PM, during an interview with R17, observation revealed that R17 was wearing glasses. R17 was asked if her glasses were working properly. R17 stated that these glassed belong to her deceased husband, but she needed to wear something. R17 stated the glasses hurt her eyes and are not comfortable. R17 was asked if she receives vision services at the facility. R17 stated she has asked the facility about seeing vision services and they have not seen her yet. R17 stated she would like to see vision services in the facility to get new glasses. On [DATE] at 8:47AM, an interview with admissions E. Admissions E was asked if residents consent to receiving ancillary services on admission. Admissions 'E stated, yes, they consent to wanting to receive ancillary services on admission. Admissions E was asked if they were responsible for filling out the form for ancillary services or just responsible for seeing if residents want to receive ancillary services. Admissions E stated, no, we don't do that in admissions, we just ask the residents admitting if they want to receive ancillary services, the social work department is responsible for getting the form filled out for Health Drive (Ancillary service provider to the facility). On [DATE] at 8:58AM, record review of the electronic medical record (EMR) revealed a Health Drive consent form for ancillary services is signed and dated [DATE]. On [DATE] at 9:44AM, an interview was conducted with Social Worker (SW) C. SW C was asked what the process is for signing residents on to ancillary services. SW C stated, we (social work) get out and get the consents, we do the resident first meeting and that gives us the information we need to know if the resident needs ancillary services. Then we get the consent signed and get them started. During the quarterly meeting on [DATE], R17 stated she wanted to see vision services and consented to all of the ancillary services. SW C was asked when vision services were last in the facility. SW C stated they were here on [DATE]rd, 2025, they were scheduled for February 3rd, 2026, but had to cancel and they will be back out on February 17th, 2026. R17 will be on the list. SW C stated, that during the initial first meeting, if the residents don't indicate any need for services, then they don't sign up. A lot of residents are here short term, so they don't sign up at all. If the family, resident or physician indicate a need, then we can sign them up and they can start services. We don't have to wait until the quarterly meeting to get them started on services, but that is a good time to follow up. On [DATE] at 9:55AM, record review of the EMR revealed an observation form titled, Trilogy Resident First Meeting Minutes, 3.7.25 dated [DATE], that indicates that R17 consented to being signed on with health drive for ancillary services. On [DATE] at 10:00AM, record review of the EMR revealed a care plan in place that R17 has potential for impaired vision related to cataracts and presence of intraocular lens. Dated [DATE]. On [DATE] at 10:08AM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA was asked if R17 should have been signed up for ancillary services at the time of that meeting on [DATE]. The NHA stated, that would be our normal process, if the resident indicated they wanted services we would sign them up at that time. Review of the policy titled, Resident's First Meeting Guidelines, revealed, 10. Questions should be answered to the best of the team members' ability. The Resident First Meeting is a time to communicate information related to care needs and medical condition and seek input from the resident or representative. If there are specific concerns or complaints that may be too lengthy to properly address, the resident or representative should be directed to the appropriate department head or the Executive Director for resolution to these issues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure Infection Prevention and Control standards of practice were followed for 1.) Personal Protection Equipment/PPE use and hand hygiene during wound care for one resident (Resident #7) in Enhanced Barrier Precautions, and 2.) the 300 Hall Medication room had a lack of access to the sink to perform hand washing, including IV supplies for one resident (Resident #14) stored under the soap dispenser. Findings Include: Medication room [ROOM NUMBER] Hall: On 2/10/2026 4:29 PM, during a tour of the 300-hall medication room with Nurse N, 2 large carboard boxes of apple sauce were observed stacked on the counter next to the sink. Both were underneath the soap dispenser. In addition, bags of IV antibiotic supplies for a resident were stacked on top of the applesauce boxes. There was also a large empty medication return bag on the counter. There was no counter space for medication preparation or for the nurses to wash their hands. On 2/10/2026 at 4:45 PM, the 300-hall medication room was reviewed with Unit Manager O. The boxes of applesauce and IV supplies were next to the sink and under the hand soap dispenser. It was observed there was no open counter space or way for a nurse to wash their hands without contaminating the IV supplies, apple sauce boxes or other items in the area. Nurse O stated, It should not be like that; I will take care of it. On 02/09/2026 at 10:04AM, During a walk-through observation of assigned residents' unit, 7 resident doors had enhanced barrier precaution (EBP) signs posted outside and 5 of the 7 rooms that were identified had a shared occupancy. There was no indication as to which resident in the shared rooms had been identified for the enhance barrier precautions. On 02/09/2026 at 10:10AM, During an interview with medication tech M she was asked how staff identified which resident in a shared room was in EBP's, she said it was indicated on the EBP sign. Medication tech M was asked to identify where on the signs the information was located. Medication tech M walked to a room with an EBP sign posted outside and confirmed it was not marked with bed A or bed B. Medication tech M said all the EBP signs were 'supposed to indicated bed A or bed B' to identify the resident confidentially. On 02/09/2026 at 10:42AM, During an interview with medication tech L she was queried on how to identify which resident required EBP's in a shared room and she pointed to an EBP sign on a resident's door, the sign had bed B written in purple marker on it. When she was asked when the signs were marked for identification and she indicated 'this morning' and further said that all the rooms with EBP signs down that hall now had bed A or bed B identified on them. R7: According to a review of R7's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to diagnoses of Acute post hemorrhagic anemia (blood loss and low blood count), chronic obstructive pulmonary disease (COPD), chronic respiratory failure, atrial fabulation (AFIB/ irregular heart rhythm), and diabetes mellitis type II (DM). R7's Minimum Data Set (MDS) record revealed a Brief Interview of Mental Status (BIMS) assessment score of 10/15 indicated resident had moderate cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/09/2026 at 10:47 AM, An Observation of R7's door indicated that EBP was in place for bed B, R7 was the resident in bed B. During an interview with R7 she said she had a wound on her leg that was healing well, and she was not worried about that anymore and said that she had a wound on her bottom that was 'new'. When R7 was asked to define how new it was, she confirmed that it was within the past couple of weeks. R7 said it was very sore, and she was concerned since she had an infection in her leg already. R7 said that they change her dressing on her bottom about every 3 days. R7 was agreeable to an observation of the area when her wound care was to be done. On 02/10/2026 at 08:22 AM, Nurse J was queried about R7's sore bottom and the wound care schedule, Nurse J said wound care was done on nights and was scheduled every other day. Record review of R7's orders revealed: Date: 02/04/2026: preventative- apply foam dressing to Coccyx, change every five days. Special instructions change PRN with (when) soiled. Once a day every five days 6:30 PM to 11:00 PM Date: 02/09/2026: Staff to use enhanced barrier precautions, wearing a gown and gloves at minimum during high-contact care activities. On 02/10/2026 at 02:24 PM, Nurse J was asked to check when the last treatment was done for R7's Coccyx dressing, Nurse J said she was not sure she looked at R7's record and said it was due that evening. Nurse J was asked for an observation of R7's wound care on Coccyx since R7 had complained about the area as 'being sore' and R7's order was scheduled and PRN (as needed). Nurse J agreed and gathered the wound care supplies. R7 agreed to the observation and wound care. Nurse J entered R7's room for wound care (no PPE worn), placed the supplies (gauze pads, sterile water bottle, marker and new dressing) on R7's bed tray (R7's water, books and other food items were present on the bed tray) Nurse J did not clean the bed tray nor put a barrier down before placing supplies on it. Nurse J washed her hands and put on gloves. Nurse J opened the foam dressing, placed the foam dressing on top of the opened wrapper then used the marker to date and initial the back of the dressing. Nurse J removed R7's dressing (observation of the old dressing revealed the date 2/8 BK) Nurse J laid the soiled dressing on R7's bed by her legs and continued with wound care. Nurse J wearing the same gloves then grabbed the sterile water bottle opened it then opened and moistened the gauze pads. Nurse J was wiped up and down, side to side (she did not change the gauze or follow a clean to dirty method). R7 indicated the area that was sore and Nurse J continued to use the same gauze and wiped the area again as she visualized the spot R7 referenced as 'sore'. Nurse J threw the piece of gauze away; the soiled dressing remained on the bed. Nurse J wearing her original gloves then grabbed the clean foam wound covering from the bed tray and placed it on R7's Coccyx. Nurse J then grabbed the old dressing off R7's bed and threw it in the trash. Nurse J wearing her original gloves reached over R7 and pulled her blankets up and straightened them. It was observed that Nurse J wore the same gloves throughout wound care with no hand hygiene, she recapped the sterile water, handled the call light, blankets and the bed remote after wound care with soiled gloves. After readjusting R7, Nurse J threw away the rest of the supply wrappers then removed and discarded her gloves. Nurse J said she was going to let the provider know that the area was sore and had some breakdown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the wound care observation of R7 it was revealed she had a red area of moisture associated skin damage (MASD) about the size of a dime noted on the right coccyx, that matched the area R7 indicated was 'sore'. Nurse J took the sterile water bottle off the bed tray and walked into the hall. When asked what she was going to do with the sterile water she stated, date it and indicated it was good for 'a while after being opened' and walked away. When Nurse J returned she was queried about which resident in R7's room was on EBP, she stated (R7), is for her wounds. Throughout the observation of Nurse J's wound care for R7 there was a lack of barriers used, disposal of soiled supplies, wound hygiene, hand hygiene, and proper PPE for EBP identified resident. On 2/11/2026 ICP meeting at 8:20 AM During an interview, ICP Nurse H was asked how staff and visitors identified which resident in a shared room has EBP and need for additional PPE. ICP Nurse H said the staff looked it up in the residents' chart and said they noted bed A or bed B on the signage, so it was readily identifiable. ICP Nurse H said that was a newer practice for them. ICP Nurse H was queried about wound care for residents in EBP. ICP Nurse H explained that wound care was considered a high contact activity and required PPE for residents in EBP. Areas of concern from the observed wound care was reviewed with ICP Nurse H and she agreed that infection control standards were not followed. On 2/11/2026 at 3:35PM, During an interview wound care Nurse I was asked about wound care, EBP and PPE. Wound care Nurse I said that residents in EBP would require PPE of gown, gloves and potentially a mask for high contact activities. Wound care Nurse I was asked and agreed that a dressing change on the coccyx was a high contact activity. Wound care Nurse I explained that Nurse J came from the hospital setting and was not used to EBP because it was not widely used in the hospital setting. Wound care Nurse I was asked if Nurse J had been educated on EBP and she replied yes, all care staff are given competency on EBP. Wound care Nurse I was asked about the reason for R7's EBP and she said R7 had Methicillin resistant Staphylococcus Aureus (MRSA) in her left lower leg wound. Areas of concern from the observed wound care were reviewed with wound care Nurse I and she agreed that basic standards of wound care were not followed for R7 by Nurse J. Wound care Nurse I said she had verbally re-educated the staff on duty about EBP and presented a list dated 02/11/2026 with ~10 staff names. Wound care Nurse I further explained that she was going to clean the treatment cart and remove the contaminated bottle of sterile water that was used by Nurse J during wound care for R7. A record review of the facilities policy on hand hygiene revealed: Purpose Statement: The purpose of this policy is to: Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol˜based hand rub (ABHR). 1. All health care workers shall utilize hand hygiene frequently and appropriately. 3. Health Care Workers (HCW) shall use hand hygiene at times such as. c. Before/after having direct physical contact with residents. d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc. A record review of the facilities standard operating procedure on enhanced barrier precautions revealed: (continued on next page)

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