STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235663	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notting Hill of West Bloomfield	6535 Drake Rd West Bloomfield, MI 48322

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. This citation pertains to intake 2793611.Based on observation, interview and record review, the facility failed to honor mealtime preferences for six of eight confidential residents that attended the resident council meeting, resulting in expressed feelings of discontent, isolation from peers and loss of autonomy. Findings include:Review of allegations reported to the State Agency included concerns that the resident was given the incorrect diet.On 3/23/26 at 12:27 PM, observation of the facility's main dining room revealed there were nine residents present. Residents were observed interacting with one another and staff were observed obtaining orders for the meal from each resident (Restaurant-like style).On 3/24/26 at 11:00 AM, a confidential meeting was held with eight residents that usually attended the facility's resident council meetings. When asked about how they felt the facility's dining/meal process was, six of the eight residents voiced concerns that the dining room was closed frequently, including not open at all on the weekends. The residents reported they enjoyed getting out of their rooms and socializing in the dining room during meals, and that when they ate in the dining room their meals were warm and they received all of the food items on the menu.Several residents reported that when they received meal trays to their room when the dining room was closed, they were often missing items despite what they pre-filled out on the menu selections for the week.Several other residents reported they were always offered soup and salad when they went to the dining room but that did not occur when they ate in their rooms.The residents reported the dining restrictions had been in place for a long time and expressed their frustration over their loss of choice to eat their meals in the main dining room. Several residents also reported their perceptions were the dining room was opened this week due to the State Agency being in the building.On 3/24/26 at 12:38 PM, an interview was conducted with the Director of Nursing (DON). When asked about who determines when the main dining room is open or not, the DON reported that was up to the Dining Manager (DM ?L').On 3/25/26 at 4:20 PM, an interview was conducted with DM ?L'. When asked about how it was determined the main dining room stayed open or closed, DM 'L' reported the dining room would only close if there was an emergency. When asked what they would classify as an emergency, DM ?L' reported that would be if there was an issue like an outbreak (infection control). DM 'L' further reported they had recently closed the dining room due to a fuse box issue with the dish machine and the main dining room had been closed for about four or five days. When asked when this occurred, DM 'L' reported earlier this month.When asked about the closure of the dining room on the weekends, DM 'L' reported the main dining room was not open on the weekends. When asked for the reason it was closed on weekends, DM 'L' reported that was just their plan and since covid when all the dining rooms were shut down. DM ?L' further reported their plan was to slowly open the dining room and that it was now open Monday - Friday for all three meals. DM ?L' was requested to provide the facility's plan for the re-opening of the main dining room and reported there was no official plan to provide.According to the facility's policy titled, Meal Service dated 1/9/2025: .It is the policy of this facility to provide a dining experience that is conducive to meal acceptance, which includes a quiet, pleasant room, positive staff attitudes, and attractive meal presentation.Residents will be interviewed at the time of admission and thereafter, as needed, as to their preference to eat in the Dining Room or (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their room.According to the facility's policy titled, Resident Rights dated 5/14/2024: .Residents have freedom of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care.

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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. This citation pertains to intake 2741968.Based on observation, interview, and record review, the facility failed to provide a safe, clean, homelike environment throughout multiple resident rooms and hallways affecting multiple residents including R17, R31, R87, R91, R100, R110, R125 and eight of eight residents that attended the confidential group interview. Findings include: Observations that were conducted from 3/23/26 - 3/24/26 identified the following environmental concerns: The inner bottom portion of the handrails throughout the second-floor west hallway were observed to have food and debris (potato chips, pink and white popcorn, straw wrappers and used tissues) items that were not cleaned/maintained. Additionally, there were multiple resident room doors that were observed heavily soiled with dirt, debris and unknown substances. The private dining room doors were observed to be heavily soiled with dirt and debris and what appeared to be a liquid that had splattered and dried. On 3/24/26 at 7:56 AM, R17's room was observed to have the entire corner wall with missing drywall that was crumbled on the flooring. Additionally, the dresser was observed to have a thick layer of dust across the entire top. Resident Council Interview: On 3/24/26 at 11:00 AM, a confidential resident council interview was conducted with eight residents that normally attend the resident council meetings. When asked about if there were any concerns regarding the facility's housekeeping or maintenance concerns, multiple residents verbalized concerns. Their responses included: Been waiting to wash my carpet. It's pitch back and when I drive over it in my wheelchair, my whole hand is black from touching the wheel to move. Only in my room twice a week. My roommate uses a urinal and when he misses the urine goes on the floor and between the room divider. It will sit there for long time. It smells so bad like urine. Feel like our room should be cleaned every day. My heater filter is real thick and it stinks. They (Housekeeping Department) lost some staff. Don't see them on the weekends. Got a leak in the back of my toilet. I dump it everynight. Maintenance says he's too busy. Our toilet seat is broken. We asked him (unsure of name) last month. Can you please help us with that. It's been over a month. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/26 at 3:00 PM, an interview was conducted with the Director of Housekeeping and Laundry (Staff 'P'). When asked about their housekeeping staff and whether there were any openings, Staff 'P' reported there were no current openings for housekeeping. When asked what hours the housekeeping staff worked, Staff 'P reported they worked day shift from 8:00 AM to 4:30 PM and afternoons from 3:00 PM to 11:00 PM. At this time, Staff 'P' was requested to observe the environment. Upon observation of the environment, Staff 'P' confirmed the same findings identified above and reported the process was once the housekeeping staff were done in the rooms, they should work on the hallways and take the vacuum and go along the handrails. Staff 'P' confirmed the same food and debris remained throughout the hallway in R17's room. They also confirmed the corner metal brace was exposed and had sharp edges. The drywall pieces observed on 3/24/26 were mostly gone, however there were several large pieces of drywall under the bed. Staff 'P' reported there had been some staffing issues and they didn't work the weekends so sometimes when they came in on Monday there were housekeeping concerns that needed to be followed up on. On 3/24/26 at 4:48 PM, an interview was conducted with the Administrator. When asked about their Maintenance Staff, they reported their Maintenance Director abruptly left their position on 3/2/26 and there was a maintenance assistant that had been stepping in. The Administrator was requested to provide the electronic reporting documentation for the past three months (concerns reported by staff that needed follow up). On 3/24/26 at 5:21 PM, the Administrator was requested to observe several of the resident rooms. Observations included: At 5:21 PM, the room occupied by R17 was observed to have the broken drywall and exposed sharp metal. The Administrator reported the facility had previously had that area fixed and was not aware it was still in need of repair. At 5:25 PM, the room occupied by R87 and R110 was observed to have a loose toilet seat that was not secured and able to easily slide left to right. The Administrator reported that would be addressed and was not aware of that before now. R110 stated to the Administrator it had been like that for three weeks now and they had told a male staff about it but have not had any follow-up. At 5:30 PM, the room occupied by R31 was observed to have a small plastic basin on the floor under the pipes under the back of the toilet that was almost completely filled with water. The toilet was visibly leaking water and when the Administrator flushed the toilet, the leaking water worsened. The Administrator reported they were not aware of that. On 3/25/26 at 10:11 AM, the facility was requested for a second time to provide the electronic documentation of environmental reports from staff. Review of the documentation provided by the facility revealed a work order log from 12/1/25 – 3/25/26 that had been completed already. There was no documentation provided of existing concerns. Additionally, this documentation did not include any specific details of what date these were reported and when they were corrected. There was no documentation included for the above resident concerns. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the facility's policy titled, Housekeeping Services dated 7/8/25: .In resident care areas, cleaning of non-carpeted floors and other horizontal surfaces will be done daily and more frequently if spillage or visible soiling occurs.Carpeting will be vacuumed regularly, cleaned promptly if spills occur and shampooed every 3 to 6 months or when indicated by appearance. R125 On 03/23/2026 at approximately 9:19 a.m., R125 was observed in room, lying in bed. R125 was asked if they had any concerns and they indicated they have not had any toilet paper in their restroom to wipe their bottom since the previous night. R125 indicated that they had informed two Certified Nursing Assistants (CNA's) to refill their toilet paper, and nobody had done it. R125 reported they had to clean their self with paper towel which hurt. R125's restroom was observed to not contain any toilet paper. R91 On 03/23/2026 at approximately 9:46 a.m., R91 was observed in their room, lying in bed. R91's restroom was observed to have their Call button (a system used to notify facility staff of assistance needs) pull cord wrapped around the grab bar in bathroom rendering it non-functional for R91 to use. R100 On 03/23/2026 at approximately 10:41 a.m., R100 was observed in their room, lying in their bed. R91's room was observed to have their drywall peeling away from the walls in their room exposing the cardboard drywall underneath. R100's Call button was observed on the floor, out of reach of R100. On 3/25/26 at approximately 12:05 pm., a follow-up observation of R100's room was conducted and was observed to still have five areas of peeling drywall that was exposing the brown cardboard underneath. On 3/25/26 at approximately 12:12 p.m., R100's room was observed with Maintenance Worker A (MW A). MW A reported that R100's drywall would need to be repaired and painted. MW A was queried if they had been made aware of R100's walls needing repair and they reported they had not but that the facility used a system of notification that should have utilized and was not. MW A indicated they would have to find some time to work on R100's room because they were the only Maintenance Worker that was employed at that time as the Director had recently resigned. On 3/23/26 at 11:40 AM observed both (two) washers and dryers running and a large bin of clean linens to be folded/delivered. At this time when asked about laundry procedures, Housekeeping (HK) staff V indicated knowing basic laundry tasks, but that she was filling in to provide coverage and help catch up the laundry and her normal work is housekeeping tasks for unit/rooms. On 3/23/26 at 12:25 PM interview with Certified Nursing Assistant (CNA) GG regarding availability of clean linens, they said this is a constant issue and there are often not enough clean linens for their shower schedule. CNA GG said there were not enough earlier today, but now supply has been restocked, but it can disrupt the showering schedule. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/23/26 at 12:30 PM observed the 1st floor clean linen/supply room with approximately 20 wash cloths and 20 bath towels. Disposable briefs storage shelves appear low on supplies; there were 2 packages each of sizes M, L, 2XL. No packages of size XL. On 3/23/26 at 12:31 PM observed 1st floor soiled linen/utility room with 2 overly full garbage bins, not yet emptied. On 3/23/26 at 12:55 PM observed the 2nd floor central shower full of several pieces of stored equipment limiting the ability to move in this room: 4 shower chairs, 1 shower bed, and the therapy tub. During this observation when queried, CNA X indicated that most residents use the showers available in their rooms, there is limited but routine use of the central shower. CNA X then said that when using the central shower room, the extra items are placed into the hall temporarily. On 3/23/26 at 1:05 PM observed the 2nd floor soiled linen room with heaping full tub of bagged soiled linens and a full blue hamper with bagged soiled personal laundry items. On 3/23/26 at 1:10 PM observed the 2nd floor clean linen room with a limited supply of clean linens and disposable briefs: 1 open package size L, 4 packages size M, no packages of XL or 2XL, a stack of about 20 clean washcloths and 0 (no) clean bath towels. When asked at this time about availability of supplies, CNA W indicated that if they were short on anything they could contact Central Supply (CS) staff to re-stock. On 3/23/26 at 1:50 PM observed both washing machines running, a bin of clean linens and partially full stocked transfer cart of folded linens. During this observation, when asked, staff Z indicated they had come in early to help provide coverage. When asked about linen supply, staff Z said keeping clean towels stocked are the biggest problem and they often go missing. On 3/23/26 at 2:10 PM observed housekeeping (HK) staff Y with a wheeled bin full of toilet paper (TP) rolls, restocking the common bathrooms near service hallway. During this observation when asked if there was a TP supply issue, HK Y indicated no, there is plenty and they were trying to get the restrooms restocked. On 3/23/26 at 2:20 PM Interview with staff N to ask about any issues with supplies of linens, briefs, TP. Staff N indicated there were plenty of supplies available and that housekeeping staff are responsible for restocking TP to public restrooms and resident rooms, including on weekends. When asked about the low supply of briefs she indicated she was aware and was about to restock this afternoon that there was ample supply in central supply area. Related to staffing, when asked if that may be an issue with getting supplies to residents, staff N indicated being aware of new hires onboarding with housekeeping department. On 3/23/26 at 2:45 PM interview with the Nursing Home Administrator (NHA) regarding availability of supplies to residents. When asked about provision of TP/tissue to resident rooms on weekends, NHA indicated that housekeeping staff would provide those items, including on weekends. When asked about housekeeping staffing levels, it was indicated that there are new housekeeping staff coming to orientation. Record Review of the Notting Hill Facility Assessment 25-26 document indicated the following: page 44 Section D.1. Cultural – Sufficiency Analysis Summary: . The Housekeeping/Laundry Supervisor in conjunction with Central Supply Coordinator maintains a supply of above-mentioned supplies and products and replaces items as needed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2741968. Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 18 residents (R25, R41, R123, R46, R61, R65, R72, R78, R81, R87, R90, R91, R93 and R109) of 19 residents reviewed for abuse/neglect/mistreatment, resulting in pain, missed medication administration, treatments and assessments. Findings include: On 03/23/2026 a concern submitted to the State Agency was reviewed that alleged the facility failed to ensure a Nurse was assigned to a block of resident rooms (Rooms 125-147) on 12/28/25. On 3/24/26 at approximately 10:08 a.m., Family member Q (FM Q) was interviewed via phone pertaining to allegations that the facility did not have a Nurse assigned to the Orchard Lake block of rooms on 12/28/25. FM Q reported that R123 not receive any of their day shift medications on 12/28/25 until approximately 9:00 PM. FM Q indicated they drove up to the facility in the afternoon and addressed the concern with Nurse J who informed them that no Nurses were assigned to the Orchard Lake hallway, and none of the Nurses in the facility could take on the hall due to them putting their license at risk in caring for so many residents. R123 On 3/24/26 the medical record for R123 was reviewed and revealed the following: R123 was initially admitted to the facility on [DATE], discharged on 1/8/26 and had diagnoses including Congestive heart failure and Atrial Fibrillation. A review of R123's MDS (minimum data set) with an ARD (assessment reference date) of 11/14/25 revealed R123 needed assistance with most of their activities of daily living. A review of R123's December 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed R123 was not administered approximately 16 doses of medications/supplements and had three treatment opportunities for their urostomy not completed. Further review of the MAR and TAR for the other 17 residents on the unit revealed the following number of Medications/supplements and treatments were not administered or completed during the day shift on 12/28/25. R25-six medications, R41-10 medications, R46-six medications and 8 treatments, R61-17 medications, R65-three medications, R72-six medications, R78-15 medications and one treatment, R81-11 medications, R87-18 medications and one treatment, R90-five medications and one treatment, R91-12 medications and four treatments, R93-13 medications, R109-nine medications and two treatments, R127-seven medications, R128-11 medications, R129-five medications and one treatment, R130-nine medications and two treatments. On 3/24/26 a copy of the facility Nurse staffing assignment was reviewed and revealed no Nurse (Nurse J) was scheduled to work the first floor that had a census of 38 residents on the floor and Certified Nursing Assistants S and T (CNA) were assigned to the Orchard Lake rooms (125-147) during the day shift on 12/28/25. On 3/24/26 at approximately 12:35 p.m., Certified Nursing Assistant S (CNA S) was queried regarding the allegation of no Nurse being present for the 125-147 rooms on 12/28/25 during the day shift. CNA S reported they were one of the CNA's for the Orchard Lake rooms that day and they remembered that day and there was no Nurse for those rooms. CNA S reported that occasionally the other Nurse from the other hallway on the first floor would come over to the unit, but they believed that nobody was given any medications, but the Nurse had their own hall to give medications. On 3/24/26 at approximately 12:45 p.m., CNA T was interviewed pertaining to the allegation of no Nurse being assigned to the 125-147 room on 12/28/25. They reported they were assigned to the unit that day and there was no Nurse during the day shift, and they remembered many of the residents were in pain because they had to be changed without any pain medications. On 3/24/26 at approximately 3:01 p.m. The Director of Nursing (DON) was queried regarding the 18 residents that had resided on rooms 125-147 on 12/28/25. The DON indicated they were unaware of the hallway not having an assigned Nurse. The DON reported that if the facility has a low census, they schedule three Nurses who are to divide up the facility, and one Nurse will have to do a split floor. The DON was queried if they were made aware of any Nursing shortages on 12/28/25 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and they indicated they were not. On 3/25/26 at approximately 8:15 a.m., during a follow up conversation with the DON, the DON indicated that the census on 12/28/25 was 86 so the facility would have three Nurses, and they should have spit up the building between the three of them with one of the Nurses on the second floor having to have a split set between the first and second floors. The DON indicated that there may have been a miscommunication regarding Nursing assignments. The DON indicated they ran a missed medication report for that day which resulted in 15 pages of residents with missed medications. On 3/25/26 at approximately 10:01 a.m., Nurse J was interviewed by phone and asked about staffing in the facility. Nurse J explained staffing had been poor lately. Nurse J was asked how many nurses were usually scheduled. Nurse j explained usually there were four nurses scheduled, two for each floor. Nurse J was asked if there were ever only three nurses scheduled. Nurse J explained it had happened a couple of times, but she had told them she could not split the building like that, with the nurses covering two floors. On 3/25/26 at approximately a facility document titled Abuse Prohibition Policy was reviewed and revealed the following: Policy-Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for purposes of discipline or convenience that are not required to treat the guests/resident's medical symptoms To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an ongoing basis. It is the responsibility of all staff to provide a safe environment for the guests/residents Neglect is the failure of the facility, its employees or service providers to provide goods and services to a guest/resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware, or should have been aware of, goods or services that a guest/ resident(s) requires but the facility fails to provide them to the guest(s)/resident(s), resulting in physical harm, pain, mental anguish or emotional distress. Alleged violations of neglect include cases where the facility demonstrates indifference or disregard for guest/resident care, comfort or safety, resulting in physical harm, pain, mental anguish or emotional distress .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2679285 and 2741968.Based on observation, interview and record review, the facility failed to ensure medications were administered in accordance with physician orders for four (R43, R44, R87 and R110) of four residents reviewed for medication administration, and five of eight residents that attended the confidential group interview; And the facility failed to ensure wound dressings were identified, assessed, changed per physician orders and/or dated for two (R13 and R112) of three residents reviewed for skin conditions. Findings include:Review of multiple complaints reported to the State Agency included allegations that medications were not being administered per physician orders. On 3/24/26 at 11:00 AM, a confidential resident council interview with conducted with eight residents that normally attend the resident council meetings. When asked if anyone had concerns with their medication administration, five residents verbalized concerns. Their responses included: Last night in our wing, we didn't have a Nurse until 12:00 AM. The day nurse was here all day. So when they are late with medication, what are we supposed to do? Double up? That's a big problem. They sit and talk at the nursing station I know cause I have to find the nurse to pass the medications. They will be there yapping away. I haven't had my morning meds yet. My pain patch is supposed to be given between 9:00 AM and 10:00 AM. Three additional residents reported they also had not received their 9:00 AM medication as of now. Review of the following Medication Administration Records (MARs) for the following residents revealed as of this review on 3/24/26 at 12:40 PM, none had received their scheduled 9:00 AM medications/treatments. Additionally, there was no documentation such as progress notes, physician notification of missed/late administration and/or further directions to hold or continue with administration for any of the above residents. R43 Review of the clinical record revealed R43 was admitted into the facility on 8/9/22 with diagnoses that included: unspecified atrial fibrillation, other symptoms and signs involving the musculoskeletal system, muscle wasting and atrophy, iron deficiency anemia, primary insomnia, mild cognitive impairment of uncertain or unknown etiology, generalized anxiety disorder, dysthymic disorder, other specific arthropathies, unspecified systolic (congestive) heart failure, major depressive disorder recurrent mild, hyperlipidemia, GERD, depression, type 2 diabetes mellitus without complications, orthostatic hypotension, and hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease. Current medications included: Cholecalciferol Tablet 1000 UNIT Give 1 tablet by mouth one time a day for Supplement. Famotidine Tablet 20 MG (Milligrams) Give 1 tablet by mouth one time a day for GERD (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Gastroesophageal reflux disease). Ferrous Sulfate Oral Tablet 325 MG Give 1 tablet by mouth on time a day every other day for iron deficiency. Folate Oral Tablet 400 MCG (Folic Acid) Give 400 mcg (Micrograms) by mouth one time a day for Folate deficiency with anemia. Furosemide (Lasix – a diuretic) Oral Tablet 40 MG Give 1 tablet by mouth one time a day for chf (Congestive Heart Failure). Lidocaine External patch Apply to Right shoulder topically one time a day for Right shoulder pain Keep on for 12 hours then remove. Lisinopril (for blood pressure) Oral Tablet 10 MG Give 1 tablet by mouth one time a day for Hypertension HOLD SBP (Systolic Blood Pressure) <100mgHg (millimeters of mercury). Potassium Chloride ER (Extended Release) Oral Tablet Extended Release 20 MEQ (Milliequivalent) Give 2 tablet by mouth one time a day for hypokalemia. Eliquis Tablet 5 MG (Apixaban) (An anticoagulant/blood thinner) Give 1 tablet by mouth every 12 hours for A-fib (Atrial Fibrillation). R44 Review of the clinical record revealed R44 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute and chronic respiratory failure with hypoxia, streptococcal infection (2/26/26), chronic obstructive pulmonary disease, chronic right heart failure, pseudomonas, injury of right quadriceps muscle, fascia and tendon, morbid obesity due to excess calories, other depressive episodes, other iron deficiency anemias, hyperlipidemia, Von Willebrand disease type 1, acute on chronic systolic (congestive) heart failure, generalized anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, primary insomnia, essential hypertension, hereditary factor IX deficiency, unspecified atrial fibrillation, and muscle wasting and atrophy. Current medications included: Amiodarone HCl Oral Tablet 200 MG Give 1 tablet by mouth one time a day for atrial fibrillation. Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Actuation) 1 spray in both nostrils one time a day for allergy symptoms. Folic Acid Oral Tablet 1 MG Give 1 tablet by mouth one time a day for supplement. Jardiance Oral Tablet 25 MG (Empagliflozin) (a diabetes medication) Give 1 tablet by mouth one time a day for DM2 (Diabetes Mellitus Type 2). Spironolactone Oral Tablet 50 MG Give 1 tablet by mouth one time a day for DIURETIC. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Apixaban (an anticoagulant/blood thinner) Oral Tablet 5 MG Give 1 tablet my mouth two times a day for DVT. This was to be given scheduled at 9:00 AM and 9:00 PM. Bumex Oral Tablet 0.5 MG (Bumetanide) Give 3 tablet by mouth two times a day for DIURETIC. Carvedilol Oral Tablet 25 MG Give 1 tablet by mouth two times a day for HTN (Hypertension). Guaifenesin ER Tablet Extended Release 12 Hour 600 MG Give 1 tablet by mouth every 12 hours for cough. Hydralazine HCl Oral Tablet 50 MG Give 1 tablet by mouth every 12 hours for HTN. This was to be given scheduled at 9:00 AM and 9:00 PM. Sacubitril-Valsartan Oral Tablet 97-103 MG Give 1 tablet by mouth two times a day for HEART FAILURE. This was to be given scheduled at 9:00 AM and 9:00 PM. Isosorbide Dinitrate Oral Tablet 20 MG Give 1 tablet by mouth three times a day for HTN. This was to be given scheduled at 9:00 AM, 1:00 PM, and 9:00 PM. R87 Review of the clinical record revealed R87 was initially admitted into the facility on 6/10/25 and readmitted on [DATE] with diagnoses that included: acute on chronic systolic (congestive) heart failure, chronic obstructive pulmonary disease, heart failure, obstructive sleep apnea, obesity due to excess calories, other instability left hip, fracture of unspecified part of left femur, essential hypertension, hyperlipidemia, anxiety disorder, anemia, GERD, vitamin D deficiency, chronic viral hepatitis C, gout, type 2 diabetes mellitus with diabetic neuropathy, other abnormalities of gait and mobility. Current medications included: Aldactone Oral Tablet 25 MG (Spironolactone) Give 1 tablet by mouth one time a day for Fluid Retention. Bumetanide Tablet 2 MG Give 1 tablet by mouth one time a day for fluid retention. Ferrous Sulfate Oral Tablet Delayed Release 324 (65 Fe) MG Give 1 tablet by mouth one time a day for Anemia. Jardiance Oral Tablet 10 MG (Empagliflozin) Give 1 tablet by mouth one time a day for Diabetes Mellitus. Lidocan [sic] External Patch 5% (Lidocaine) Apply to skin topically one time a day for pain and remove per schedule. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG Give 1 tablet by mouth in the morning of GERD. Toprol XL Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 11 tablet by (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mouth one time a day for Hypertension. Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT (Fluticasone-Umeclidinium-Vilanterol) 1 inhalation inhale orally one time a day for COPD. Ammonium Lactate Solution Apply to affected areas topically two times a day for dry skin apply to affected areas. Scheduled to be administered at 9:00 AM and 5:00 PM. Entresto Oral Tablet 24-26 MG Give 1 tablet by mouth two times a day for Heart Failure. Scheduled to be given at 9:00 AM and 5:00 PM. Gabapentin Oral Tablet 600 MG Give 1 tablet by mouth three times a day for neuropathy. Scheduled to be given at 9:00 AM, 1:00 PM, and 9:00 PM. Insulin Lispro Injection Solution 100 UNIT/ML Inject as per sliding scale: If 70 - 150 = 0 units; 151 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units IF BLOOD SUGAR GREATER THAN 400, GIVE 6 UNITS AND CONTACT MD, subcutaneously before meals and at bedtime for DM2. As of this record review on 3/24/26 at 12:40 PM, this was last documented as completed on 3/24/26 at 7:00 AM. R87 was already observed in the dining room at this time and there was no documentation their blood sugar had been checked. Additionally, the MAR documentation revealed R87 frequently received sliding scale insulin coverage before meals. R110 Review of the clinical record revealed R110 was admitted into the facility on 3/4/25 with diagnoses that included: unspecified dementia unspecified severity with other behavioral disturbance, dysthymic disorder, essential hypertension, GERD, obesity, hyperlipidemia, type 2 diabetes mellitus without complications, vitamin D deficiency, other specified arthritis right and left hand, carpal tunnel syndrome left upper limb, anemia, acquired absence of right leg below knee and unspecified urinary incontinence. Current medications included: Bupropion HCl (Hydrochloride) ER (XL) Tablet Extended Release 24 Hour 150 MG Give 1 tablet by mouth one time a day for depression. Claritin Oral Tablet 10 MG (Loratadine) Give 1 tablet by mouth one time a day for itching for 14 Days. This was started on 3/13/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate) Give 75 mg by mouth one time a day for DVT (Deep Vein Thrombosis – Blood Clot) Prevention. Eucerin External Lotion (Emollient) Apply to bilat (bilateral) dry skin topically one time a day for Xerosis cutis (dry, rough, scaly skin). Ezetimibe Oral Tablet 10 MG Give 10 mg by mouth one time a day for Hyperlipidemia. Active Liquid Protein two times a day Active Liquid protein 30 mL (milliliters) BID (twice a day) or any available nutritional supplement. Nursing to provide. Ordered to be given scheduled at 9:00 AM and 5:00 PM. Diclofenac Sodium External Gel 1 % Apply to Hands bilaterally 2gm (Grams) topically every morning and at bedtime for arthritis pain. On 3/24/26 at 12:30 PM, Nurse 'R' who was assigned to the 2 East unit was asked about their morning medication pass and if they were completed with their morning medication administration. Nurse 'R' reported they were not because it was a heavy med pass and they had the back half to finish. When asked if they had notified anyone from Administration or the Physician that the medication administration was delayed, Nurse 'R' reported they did not. On 3/25/26 at 1:24 PM, an interview was conducted with the DON. When asked about what their policy was regarding late and/or missed medications and treatments, the DON did not offer any explanation but reported they could pull up the facility's Medication Administration policy for review. Review of the policy with the DON revealed this policy did not address late/missed medications and treatments and when asked for further explanation, the DON offered no further response. Further review of R43's MAR with the DON on 3/25/26 at 2:03 PM revealed R43's MARs had no documentation for the above medication/treatments documented as administered today. The MAR remained blank for all 9:00 AM medication. When asked if they had been notified of any concerns with late medication administration today, the DON reported they had not and was unable to offer any further explanation. According to the facility's policy titled, Medication Administration dated 10/17/2023: .Medications are administered in accordance with written orders of the attending physician .Document the interaction with the physician in the progress notes and elsewhere in the medical record, as appropriate .Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. For example, if the medication is ordered for 8:00 a.m., it must be given between 7:00 a.m. and 9:00 a.m. in order to be considered timely . R112 On 3/23/26 at 11:01 AM, R112 was observed seated on the side of bed. Their pant legs were above their knees and the right leg was observed with two red ribbons tied around a white bandage that was visibly soiled (grey in appearance in some areas with visible saturation) that was dated 3/17. When asked about the bandage, R112 reported they had fallen down a while ago but were feeling better now. When asked if anyone had offered to change the dressing (since date of 3/17 on bandage) and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident stated no. On 3/23/26 at 1:37 PM, an interview was conducted with R112's Nurse (Nurse 'U') who reported they were in training with Nurse Manager (NM 'M'). Nurse 'U' was asked about R112's bandage to the right knee and at that time, Nurse 'U' observed R112's dressing, confirmed the date of 3/17 and the condition of the bandage was soiled and saturated and reported they would have to change that. Nurse 'U' then requested NM 'M' come to review and when asked about the treatment and conflicting documentation on the TAR that the resident's treatment had been completed on 3/18 and 3/20, NM 'M' offered no further explanation. Review of the clinical record revealed R112 was admitted into the facility on 4/26/23 with diagnoses that included: acute systolic heart failure, anxiety disorder, major depressive disorder recurrent, insomnia, peripheral vascular disease, abdominal aortic aneurysm without rupture, and type 2 diabetes mellitus with other circulatory complications. According to the Minimum Data Set (MDS) assessment dated [DATE], R112 had intact cognition and had no skin concerns. Review of the care plans included: (R112) has Actual impairment to skin integrity r/t (related to) abrasion of right knee. Date initiated: 3/17/26. Interventions included: Treatment to skin impairment per order. Physician orders included: An order started on 3/17/26 read, Cleanse right knee abrasion with normal saline pat dry apply triple antibiotic ointment cover with border gauze Monday Wednesday Friday and prn (as needed). Review of the corresponding Treatment Administration Record (TAR) revealed the treatment for the abrasion was documented as completed by Nurse Manager (NM 'M') on 3/18 and 3/20 via a check mark. On 3/24/26 at 12:34 PM, the Director of Nursing (DON) was requested to confirm the Nurse's initials on the TAR from 3/18 and 3/20 and reported those were NM 'M's initials. When asked about why NM 'M' documented that had been completed when it wasn't, the DON reported they would have to follow up. On 3/24/26 at 12:38 PM, the DON reported they had spoken to NM 'M' and when asked if they provided an explanation, the DON declined to offer their response but acknowledged that was a concern and further reported they were going to issue a write up and It's not tolerated or acceptable. The DON later reported they also had further concerns and would be suspending NM 'M' pending further investigation. R13 On 3/23/26 at 10:10 AM, R13 was observed lying in bed. A bandage was observed wrapped around R13's right hand, both ends of the dressing were taped to the palm of the hand and the dressing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wrapped around the right thumb. The dressing was undated, and appeared worn and had a fringe of lint from the fleece blanket R13 had on his bed along the edge of the dressing nearest R13's fingers. R13 was asked how long the dressing had been on their hand. R13 explained he had gone to an appointment on 3/17/26 and his hand had started bleeding at the appointment, so they had put that dressing on his hand to stop the bleeding. R13 was asked if anyone at the facility had looked at the dressing or his hand. R13 explained no one had asked him anything about the dressing. An undated foam border dressing was observed on R13's left outer arm under the elbow. R13 was asked about the dressing on his left arm. R13 explained that dressing had been changed a couple days ago. Review of the clinical record revealed R13 was admitted into the facility on 2/11/26 with diagnoses that included: pleural effusion [fluid around lungs], sepsis and malnutrition. According to the MDS assessment dated [DATE], R13 was cognitively intact. Review of R13's skin impairment care plan initiated 2/11/26 read in part, .Conduct weekly head to toe skin assessments, document and report abnormal findings to the physician. Review of a Skin Check dated 3/21/26 revealed no skin issues. Review of R13's March 2026 Treatment Administration Record (TAR) revealed no physician order for a dressing on R13's left arm. However, there was a physician order with a start date 2/25/26 that read, Cleanse right arm abrasion with normal saline pat dry apply triple antibiotic ointment cover with border gauze every Monday Wednesday and Friday and prn [as needed]. The TAR was marked as completed on 3/20/26 and left blank [indicating not done] on 3/23/26. On 3/24/26 at 10:23 AM, R13 was observed lying in bed. The same soiled bandage was observed wrapped around R13's right hand. The undated dressing under R13's left elbow appeared to be unchanged. R13 was asked if the left arm dressing had been changed. R13 explained it had not been changed for a couple of days. On 3/24/26 at 2:07 PM, R13's dressings were observed with the DON. The DON asked R13 who had put the dressing on his hand. R13 explained it was put on when he went out to an appointment. The DON removed the soiled dressing around R13's right hand to reveal a crescent shaped raised black scab approximately ¾ inch x 1/4 inch on the outside of the hand between the thumb and the index finger. The DON was asked to verify there was no date written on the dressing on R13's left arm. On 3/24/26 at approximately 2:15 PM, the DON was asked if the dressing she removed from R13's right had appeared to have been old and soiled. The DON agreed the dressing was not a new dressing. The DON was asked what the proper procedure was if a resident had a dressing that there were no orders for. The DON explained she expected the nurse to do exactly what she did, remove the bandage to see what was under there, then if there was a wound to obtain orders from the physician for wound care. The DON was asked about the undated dressing. The DON explained all dressings should be dated when they were applied. Review of a facility policy titled, Skin Management revised 1/28/26 read in part, .The licensed nurse will monitor, evaluate and document changes regarding skin condition (to include: dressing, surrounding skin, possible complications and pain) in the medical record. If a new area of skin impairment is identified, notify the resident, responsible party, practitioner, DON/designee and treatment team, if appliable.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2793611Based on interview and record review, the facility failed to ensure pressure ulcer treatments were ordered, completed as ordered, wound care was provided timely, and accurate skin assessments were completed for two (R2 and R115) of three residents reviewed for pressure ulcers. Findings include:R2 Review of R2's MDS assessment, dated 3/08/26, revealed they were admitted to the facility on [DATE], with diagnoses including spinal stenosis (narrowing of spine), polyneuropathy (nerve impingement), kidney disease, and urinary retention. The skin assessment showed R2 was admitted with one stage 3 pressure ulcer (the wound dept extends beyond the skin layers) and a surgical wound. On 3/23/26 at 2:16 p.m., R2 confirmed their right foot pressure injury was on their heel, and said the wound developed at home and at the hospital, when they pushed into their mattress too hard in bed repeatedly due to back pain. R2 said their wound care at this facility was supposed to be completed every other day, without exception, and felt frustrated that their wound care was getting missed at times, or their wound was not getting wrapped correctly, as it was often too tight. R2 showed surveyor a wrap around his leg and said it hurt them. R2 said they had their wound care completed Saturday, and stated, I missed Friday.It should be done every second day no matter what. R2's nurse was notified after the interview R2 said their wound was wrapped too tightly. On 3/24/26 at 11:10 a.m., LPN C was asked about R2's wound care after review of R2's physician orders. LPN C confirmed R2 was scheduled to have wound care every Monday, Wednesday, and Friday during the Day shift. LPN C said their wound improved slightly and showed Surveyor three weeks of wound pictures since admission. LPN C said R2's wound was appropriately offloaded, per physician orders. Review of the wound pictures and measurements with Surveyor revealed the following wound description and measurements, showing L = length, W = width, and D= depth: 3/03 4.86 cm2 (1.78 L x 3.78 W x 0.1 D) – Stable, previously deteriorating. 3/11 5.9 cm 2 (3.22 L x 2.39 W x 0.0 D) – Improving (unclear as wound larger). 3/18 4.29 cm 2 (3.98 L x 1.53 W x 0.1 D) – Stable, previously deteriorating. Review of R2's March (2026) Treatment Administration Record (TAR), revealed, Cleanse right heel with normal saline (rinse), pat dry, apply collagen (wound treatment), cover border gauze (a rectangular flat clear bandage with a gauze center and adhesive border) Monday, Wednesday, Friday and prn (as needed) every day shift everyday shift Mon, Wed, and Fri. Start date 3/20/26 0700 (7:00 a.m.). Further review of R2's March (2026) TAR on 3/24/26 revealed a missing wound treatment, noted on 3/20/26, the past Friday (which was the start date). Review of R2's March (2026) TAR reviewed an earlier physician order, dated 3/06/26, which revealed, Cleanse right heel with normal saline, pat dry, apply collagen, cover with ABD pad, wrap with Kerlix (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(gauze rolled wound wrap), Monday, Wednesday, Friday, and prn everyday shift Mon, Wed, Fri. Start date: 3/06/26 and D/C (discharge date) 3/18/26. Further review of R2's TAR (earlier wound order) revealed a missing wound treatment on Wednesday, 3/11/26, which showed as a blank box, with no explanation. The treatment on 3/20/26 was blank too; it was noted the order was discharged on this same date. Wound treatment was not initialized again until Friday, 3/13/26. Review of R2's TAR revealed another active order, which read, Cleanse right heel with normal saline, pat dry, apply collagen, cover with border gaze, Monday, Wednesday, Friday, and prn as needed. Start date: 3/18/26 1315 (1:15 p.m.). Further review of this order showed missing wound treatments on Wednesday, 3/18/26 and Friday, 3/20/26, with Saturday, 3/21/26 initialed by a nurse as provided. Further TAR review showed there was a second active order which appeared to read the same, started on 3/18/26. Regardless, neither order reflected wound care being done on 3/18/26 or 3/20/26, and the wound treatment on 3/11/26 was clearly missed. Review of R2's March (2026) TAR's in their entirety showed no other entries reviewed reflected missing wound treatments on 3/11/26, 3/18/26, and 3/20/26. Review of R2's current physician order, dated 3/25/26, showed the latest treatment for R2's Stage 3 pressure injury was to clean the wound with normal saline, pat dry, apply collagen, and then cover in border gauze, Monday, Wednesday, and Friday and as needed. On 3/24/26, at approximately 5:15 p.m., Surveyor asked the Nursing Home Administrator (NHA) to observe R2's wound care on 3/25/26. The NHA said they would have wound care held for surveyor observation, as it could be completed anytime during the day. On 3/25/26 at approximately 8:10 a.m, Surveyor asked about observing R2's wound care, as scheduled and was told it had been completed already by nursing staff for the day. Surveyor had not been asked to arrive at any earlier time on this date. On 3/25/26 at approximately 11:00 a.m., R2 stopped Surveyor in the hallway, while propelling their wheelchair, and stated, My wound got worse; they used the wrong dressing. (Registered Nurse -RN K) and the doctor (unnamed) both said they (the nurses) should not have used gauze but (instead) a bandage. I am worried it (the pressure injury wound) is getting worse. R2 described to Surveyor a wrap was used instead of a bandage, so when the nurse and physician removed the dressing this morning, their wound seemed to bleed more than usual, was larger, and had worsened. On 3/25/26 at 11:07 a.m., RN K was asked about R2's report of the wrong wound care treatment being applied earlier on 3/25/26, their wound bleeding and worsening, and why this Surveyor was unable to observe R2's wound care, as scheduled. RN K shared they had been off work a week, and upon return they and the physician had begun wound care, as scheduled, and had not received a message to wait for Surveyor. RN K was asked if they had a picture of the wound, as had been noted in prior wound documentation. RN K responded when they were off, no staff had charged the camera battery, so they could not get a picture of the R2's heel wound. RN K explained their standard of wound care when asked was to get a picture of the wound every seven days, and for the camera to be charged. RN K (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said given the collagen wound treatment was applied, it would not be ideal to open the wound bandage again, as the wound treatment would have to be redone. During further interview on 3/25/26, RN K was asked about R2 reporting on this date the wrong wound care treatment being applied, and their wound worsening. RN K reviewed their documentation and reported R2's right heel Stage 3 pressure ulcer had 20% granulation tissue, 80% epithelization tissue, had serosanguineous (non-infectious) drainage, and was healing. The measurements were described by RN K as 3.0 L, 1.0 W, and 0.1 D, with no tunneling or undermining, and said they did not have the area. Upon further documentation review with Surveyor, RN K said the wound was healing, decreasing in size, and clarified R2's wound should have had a border foam dressing applied, not a Kelex wrap, which was confirmed by current physician orders. When asked to describe the difference as a certified wound care nurse, RN K said the Kerlex wraps were for cushioning and support and sometimes used for compression and was a rolled gauze type bandage and showed surveyor the same. RN K said border gauze was an actual bandage over the wound and did not circle the wound or leg and showed surveyor a large rectangular bandage with a foam border, which they said was most appropriate for R2's heel wound. Surveyor described how R2 had reported their bandage being tight (around their leg) on 3/23/26 and their nurse being made aware. RN K said no circulatory problems had been noted for R2. RN K was asked to review R2's TAR with Surveyor and understood the concerns with the missed treatments. RN K said they did the wound care treatment on the missing Wednesday treatment and said they should have marked the TAR, as that was their responsibility. Regarding the other missing dates, RN K noted the orders had changed, however understood the concern despite orders changing with missed treatments, and could not explain why the treatments were missed on the other dates. This included review of the medical record, including R2's progress notes and all wound documentation notes. Review of R2's wound care provider documentation, dated 3/25/26, confirmed RN K's wound measurements were reflected as noted in earlier interview, and the wound was described the same, and reflected as improved, with the treatment reflected as a border foam bandage (not Kerlex wrap) to be completed on Mondays, Wednesdays, and Fridays, and said R2 was using pillows for offloading. On 3/25/26 at 3:08 p.m., the concerns related to R2's missing wound care documentation and treatments per the TAR were reviewed with the DON, the missed observation, and no picture being available, per their wound care standards. The DON conveyed they understood the concerns and would be following up with RN K. The DON was given the opportunity to respond further by survey exit and did not reapproach surveyor with additional feedback. On 3/25/26 at approximately 3:45 p.m, the NHA was asked about the missing wound care observation during the Quality Assurance and Performance Improvement (QAPI) interview, and the concerns were reviewed, including R2's reporting of their wound care treatments being missed and the wrong wound treatment being applied, as confirmed by RN K. The NHA said they took responsibility for the missed wound care observation, as they did not realize the wound care team was starting treatment so early in the morning, and understood this Surveyor's described concerns. Review of a policy, Skin Management, revised 1/28/26, revealed, The policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. Overview: Residents with wounds and/ or pressure injury and those at risk for skin compromise are identified, evaluated, and provided appropriate treatment to promote prevention and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	healing. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. Practice Guidelines.3. Appropriate preventative measures will be implemented on residents identified on residents identified at risk and the interventions are documented on the care plan. 4. Residents admitted with any skin impairment will have appropriate interventions implemented to promote healing, a physician order for treatment, and skin impairment location, measurements, and characteristics documented. 5.Photos will be taken unless refused by the resident. R115 A complaint was filed with the State Agency [SA] that alleged in part, .[R115] has a bed sore. that is supposed to be cleaned and a topical ointment is supposed to be applied. he was to be laid [sic] on his side and turned from side to side which did not occur. Review of the closed record revealed R115 was admitted into the facility on 2/14/26 with diagnoses that included: sepsis, atrial fibrillation and chronic kidney disease. According to the Minimum Data Set [MDS] assessment dated [DATE], R115 had intact cognition, and had one Stage 4 [full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone] and one Unstageable [obscured full-thickness skin and tissue loss] pressure ulcers on admission. Review of a Nursing Comprehensive Evaluation dated 2/14/26 revealed R115 had skin impairment to the right heel, left heel and sacrum. There was no description of what the skin impairment was. Review of an admission Nurses Note for R115 dated 2/14/26 at 8:29 PM read in part, .Wounds noted to both left and right heels. Open wound present to coccyx. Measurement to be obtained/documented per wound care protocol, dressing in place per discharge order. Review of R115's hospital discharge paperwork dated 2/14/25 revealed detailed orders for wound care to the left buttock, coccyx to right buttock, left heel and right heel. All the wound orders included the treatments to be completed twice daily. Review of R115's physician orders revealed no wound treatments were ordered until 2/17/26 to be started on 2/18/26. Review of R115's February 2026 Treatment Administration Record [TAR] revealed no documentation of wound care until 2/18/26. Review of a SW [skin and wound] - Skin Check for R115 dated 2/17/26 at 5:57 AM documented No skin issues. Review of a SW – Skin Issues for R115 dated 2/17/26 at 8:27 AM revealed a left heel Unstageable pressure ulcer measuring 4.9 centimeters [cm] x 3.44 cm and a coccyx Stage 4 pressure ulcer measuring 4.25 cm x 3.64 cm x 1.5 cm. On 3/25/26 at 10:25 AM, the Assistant Director of Nursing [ADON] was interviewed and asked if she was the Wound Care Coordinator. The ADON explained she had been the Wound Care Coordinator and still aided with wound care. The ADON was asked about R115 being admitted on [DATE] with wounds, but not documented wound care provided until 2/18/26. The ADON explained R115 was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted on a Saturday, she worked Monday thru Friday, and the admitting nurse did not put wound treatment orders in. The ADON was asked if the wound care orders on the hospital discharge paperwork were any different than the medication orders when admitting a resident. The ADON explained there was no difference, the admitting nurse was expected to enter the wound care orders the same as the medication orders. The ADON was asked why there was no documentation of wound care until 2/18/26 if the order was entered 2/17/26. The ADON explained it was her practice to put the orders into the computer and provide the wound care that day, but the TAR documentation would start on the next day. When asked if there was any documentation that wound care had been provided prior to 2/18/26, the ADON explained there was not. Review of a facility policy titled, Skin Management revised 1/28/26 read in part, .Residents admitted with any skin impairment will have: Appropriate interventions implemented to promote healing, A physician's order for treatment, and Skin impairment location, measurements and characteristics documented.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake 2806062 and Intake 2807263. Based on observation, interview, and record review, the facility failed to prevent an injury of unknown origin for one Resident (R65) of four residents reviewed for accidents, resulting in R65 sustaining a right arm fracture during care, with increased pain and discomfort. Findings include:A Facility Reported Incident (FRI), dated 3/08/26 at 4:01 p.m., revealed, The nurse on duty was informed by a nurse aide that the resident appeared to be in pain and that her arm locked abnormally while care was being performed. The nurse assessed the resident and contacted the physician. The physician advised that the resident be sent to ER (Emergency Room) for further evaluation. At the hospital, it was confirmed that the resident had a fracture. The family was notified. The facility will conduct a complete investigation to determine the cause.Investigation Summary:.According to the physician's note and hospital records, the resident was diagnosed with a right humerus (upper arm bone between the shoulder and elbow) angulated fracture (a type of fracture where a bone is broken but not perfectly aligned, which may require surgical intervention for proper healing) of unknown origin. Hospital radiology report confirmed osteoarthritis degenerative joint disease. A complaint received by the State Agency on 3/18/26, related to this incident, alleged on 3/08/26 between 11:00 a.m. and 6:00 a.m., an incident occurred when someone pulled R65's arm during care or did a lack of care, because R65's arm was swollen and broken. This investigation further revealed regarding: .Staff Interviews and Findings: Staff who worked with the resident during the night shift reported no falls or incidents involving the resident. Staff stated that the resident slept through the night without any signs of distress. (Certified Nurse Aide -CNA BB) reported that she entered the resident's room at approximately 5:15 a.m. on March 8, 2026, to provide morning care and change the resident. (CNA BB) stated that the resident (R65) was wearing a white, pink, and blue pajama top that pulls over the head. During care, she changed the resident into a gray shirt that also pulls over the head. While assisting the resident with getting dressed, (CNA BB) noticed that (R65's) right arm appeared swollen and limp. (CNA BB) stated that while putting the shirt on, the resident attempted to help by pushing her right arm through the sleeve, and at that time the resident expressed pain. (CNA BB) reported that the resident's arm then became limp, which prompted her to immediately notify the nurse of what she observed.Additional Findings: The resident (R65) was interviewed but was unable to express or explain what may have happened due to her cognitive impairment. Camera footage reviewed during the timeframe did not show any falls or incidents involving the resident. Staff interviews were consistent and did not identify any witnessed injury event. Residents who receive care from CNA (BB) were interviewed and no concerns or complaints of abuse, neglect, or mistreatment were reported. The residents care plan was reviewed, and it was confirmed that CNA (BB) was providing care appropriately and following the residents plan of care at the time of the incident. Conclusion: Based on the information gathered, the exact cause of the injury remains unknown. The investigation did not identify any evidence of abuse, neglect, or misappropriation of resident. Due to the residents' existing conditions of degenerative joint disease, osteoarthritis, and overall medical condition, the injury appears to be an unfortunate accident that may have occurred while the resident was assisting with movement during dressing. Although the injury appears accidental, the facility will reinforce safe care practices. CNA (BB) will receive one-on-one education on proper range of motion (ROM) techniques and the importance of immediately stopping care and notifying the nurse if a resident expresses pain during care. The facility will continue to monitor the residents' condition and reinforce safe care practices to help prevent future injuries. Based on the investigation findings, the allegation of abuse or neglect is unsubstantiated. The report also showed local law enforcement was contacted about the incident, per facility policy. Review of R65's Minimum Data Set (MDS) assessment, dated 2/01/26, revealed R65 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was asked how they dressed R65 and put their shirt on them. CNA BB said they put the left side on R65 first, their weaker side, and lifted R65's arm overhead and said it was more of a stretch shirt than a regular shirt. CNA BB said R65's arm was already swollen and they didn't believe it was from dressing them. During the care, CNA BB said R65 was wincing, not exactly crying, but waving for them to stop. R65 said they didn't know anything was wrong with her arm as she had sometimes resisted care prior so they continued to get her dressed and noted R65 was a little bit more verbal than usual. When asked if they could have done anything differently, CNA BB said, I should have stopped care. CNA BB said they were suspended from work pending the investigation and given an education and told they should have stopped care when R65 showed pain and increased resistance to care. CNA BB denied seeing or hearing any fracture occurred, and believed it was possible they had fallen prior to the incident since R65's arm was swollen, but no one told them when they asked. CNA BB said they also did not stop care to determine why R65's right arm was reportedly swollen prior to dressing them. CNA BB further described once they saw R65 had increased pain, they stepped out to get R65's nurse, Licensed Practical Nurse (LPN) CC, who looked at R65's arm with them. They both noticed R65's arm dropped when lifted and LPN CC said they had to immediately send R65 out to the hospital. It was noted CNA BB reported they did not observe something being wrong with R65's arm until after they donned R65's shirt. CNA BB said, The nurse learned about it when I did. as they had noticed pain and swelling, and said, Her arm was already big and swollen. when they began dressing R65. CNA BB denied anything intentional occurred, although they were inconsistent in reporting when they observed R65's arm was swollen. Review of CNA BB's witness statement denied a fall or any abuse had occurred. Review of R65's investigation file revealed CNA BB passed their background check upon hire and had a current license when the incident occurred an at present. The investigation showed CNA BB received a reeducation from the Director of Nursing (DON) which showed they were providing care and did not stop at the point of resistance when changing R65's clothing during care. The education included providing proper range of motion and pain management of residents and stopping during the point of resistance when changing a resident's clothing. There was no abuse or intent found. Review of R65's ER report, dated 3/08/26, showed R65 had dementia and was assessed for right arm pain, swelling, and deformity, and per the facility did not fall. R65's daughter was with R65 and reported R65 was at her mental baseline and could not report to them (either) what occurred. The x-ray report showed a displaced and angulated fracture of the distal humeral meta diaphysis (area where the wide part and shaft of bone met, which is an atypical humeral fracture presentation, often from a significant trauma, a fall, or a hard twisting motion). The orthopedic team placed a long arm splint on R65's right arm and planned for R65 to follow up with them shortly to be considered for surgery. R65 was newly prescribed Oxycodone, a narcotic pain medication, for pain. Review of R65's hospital orthopedic report, dated 3/08/26, showed R65 was presumed to have had an unwitnessed fall, as the fracture appeared to be a spiral (severe) fracture of the distal (lower) humeral presumed and noted the fracture was unstable. The report revealed R65 needed to be non-weightbearing on their right arm, with follow-up recommended in one week to discuss operative verses non operative management of the fracture. On 3/24/26 at approximately 3:40 p.m., CNA S was asked what occurred on 3/08/26, as they had worked on the earlier shift and cared for R65. CNA S said R65 had not fallen to their awareness, and said no staff told them R65 had fallen. CNA S said when they arrived on their shift on 3/08/26 in the morning, R65 was not in their room and the nurse told them R65 was at the hospital. CNA S then asked the question, and no one told me she fell. CNA S said they worked with R65 almost every day and were concerned about the fracture but did not know how it had occurred. On 3/24/26 at approximately 3:51 p.m. and 3:52 p.m., R65's day shift nurse was called, LPN EE, who worked a 12-hour shift on 3/07/26 and 3/08/26, with no answer. On 3/24/26 at 4:17 p.m., the Medical Director, Physician DD was called at 4:17 p.m., and asked about R65's right arm fracture, what had occurred, and the cause. Physician DD reported while they were not their regular medical provider, they came to see R65 shortly after the incident, on 3/10/26. Physician DD said they saw R65 because (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	p.m., the DON acknowledged they were the primary investigator of the incident and summarized their findings. The DON reported that the family had been with the resident and proven this which gave a specific time stamp to what had occurred and who to interview. The DON said they spoke to another resident across the hall, who had confirmed with them and the family that nothing had occurred that night out of the ordinary, as they had good cognition and were observant. The DON said Resident from across the hall told them R65 had a quiet night and did not start yelling out until the early morning, when R65's right arm injury was discovered and R65 was sent out emergently after. The DON denied having a witness statement from R46 when asked. The DON further conveyed their investigation determined given the other Resident's report, family observations, staff interviews, and their own investigation, they believed the chances R65 fell and injured their right arm were unlikely. The DON said Physician DD indicated R65 could have sustained the fracture from a plethora of things, as she was [AGE] years old, not walking, had limited range of motion, osteoarthritis, functional quadriplegia (inability to move), and muscle atrophy (muscle wasting away from lack of use). The DON was asked what they determined was the root cause of the fracture. The DON said when they interviewed CNA BB, she said R65 was hollering while being dressed and it escalated from her normal hollering and R65 became more resistant to care and the aide, CNA BB, did not stop when she felt resistance. The DON said, When it had changed.that is when CNA BB should have stopped. Given this and their investigation findings, the DON was asked if this was an avoidable incident/accident. The DON denied the incident being avoidable, given R65's comorbidities and arthritis, and said they were just educating CNA BB, not acknowledging wrongdoing. The DON confirmed CNA BB was suspended and had no other disciplinary action. CNA BB's date of hire was on 9/23/25. Surveyor asked for their orientation and abuse and dementia training. Review of CNA BB's orientation showed they received training in resident care and had completed their abuse and dementia training since their date of hire. On 3/24/26 at 6:30 p.m., LPN CC returned call and described the incident occurred per their progress note. LPN CC added CNA BB came and got them and they saw R65's hand was not moving and the upper part of her hand was not straight and R65 was shouting and screaming when they tried to assess her arm, which was not normal for R65. LPN CC said they saw the joint was not connected and when they lifted R65's hand, it fell back. LPN CC said they immediately called the on-call facility physician team, who wanted them to wait for an x-ray, and LPN CC told them she needed an ambulance, and the physician then agreed. LPN CC acknowledged they did not do a nursing assessment form. LPN CC said they asked staff and there was no report of R65 falling by staff, and said, Nobody told me a fall happened . LPN CC said R65 was not in pain unless their arm was moved so they did not complete a pain assessment. LPN CC said they did not know how the incident occurred. The DON confirmed afterwards LPN CC should have known to complete a transfer form. Review of R65's Accident and Incident report, dated 3/08/26, showed a similar description of the incident. No fall was mentioned. Review of R65's Physical Therapy evaluation from June 2025, showed R65's upper extremity range of motion was within normal range. Occupational therapy records showed R65 had not been on caseload seen since 2023. Quarterly therapy screenings since that time showed R65 had no change in status, with the last one completed in January 2026. There was no documentation found of contractures for this resident. Review of R65's Care Plan, accessed 3/24/26, showed R65 was dependent for feeding since 2024, and was dependent for all care for an extensive time prior to their injury. Review of R65's March (2026) medication administration treatment record showed they received three doses of Oxycodone pain medication after the incident on 3/08/26. Review of the facility investigation showed abuse was not substantiated. Review of facility documentation of R65's hallway camera footage from 3/07/26 and 3/08/26, completed by the Administrator, showed no evidence of staff entering R65's room with a mechanical lift or any concerns with additional observations. On 3/25/26 at 10:12 a.m., the Unit Manager, Licensed Practical Nurse (LPN) C, was asked about R65's injury on 3/08/26. The LPN reported they checked and R65 had not fallen per their awareness and said they had checked facility documentation and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	found no falls at or near that time and said they believed the fracture occurred from their disease process. LPN C said they had no evidence of abuse or had found any abuse concerns on R65's hall. Review of R65's pain log was reviewed and noted R65 had 8/10 pain on 3/08/26 at 16:05 (4:05 p.m.), upon return to the facility after the incident. On 3/25/26 at 10:43 a.m., another attempt was made to reach LPN EE by phone. No call was returned by survey exit. On 3/25/26 at 10:45 a.m., a telephone call was placed to the local police department. It was learned the report could not be accessed as the investigation remained open. A message was left for the police officer assigned; a call was not returned. On 3/25/26 at 11:00 a.m., R65 was observed in their room, up in their Geri chair, with the cast remaining on their right arm and their right arm supported. R65 was smiling. On 3/25/26 at 11:05 a.m, R65's aide, CNA S, was asked about R65's right arm use before their fall. CNA S said R65 required extensive assistance with feeding prior to their injury using their right arm and hand, and denied she had any arm contractures. CNA S described R65 could assist only when something was placed into their hand, such as a sandwich or a drink. CNA S said R65 communicated little and could only sometimes answer yes/no or say a few words but not consistently. CNA S was asked if R65 went to their follow-up orthopedic appointment on 3/24/26, as scheduled, and said they missed it. CNA S said according to R65's daughter, transportation was late. On 3/25/26 at 11:39 a.m., Occupational Therapist (OT) H confirmed they were covering the department in lieu of the Rehabilitation Director being out of the country and was unavailable for phone interview, despite being most familiar with R65. OT H reviewed R65's physical therapy and occupational therapy records with Surveyor and confirmed R65 had last been seen by occupational therapy on 2/03/23. R65's records at that time showed R65 was dependent for feeding and had diminished arm strength. OT H said they were unfamiliar with this resident, other than record review. OT H was asked about R65's fracture and if it could have occurred while being dressed. OT H said a spiral twisting fracture could have happened with any twisting movement and it was possible from getting dressed. OT H confirmed if R65 had weakness then the most impaired arm would get dressed first. When asked if CNA BB should have continued dressing R65 when they resisted, OT H said one should never dress someone who is resisting or make them get dressed. OT H clarified since R65 had Alzheimer's dementia she may not have wanted to get dressed due to her cognition and said if a resident did not want someone touching their arm they would guard it and resist. OT H clarified a resident including R65 should never be dressed if they were resisting in any way, and then said they did not know R65 broke their arm during care. On 3/25/26 at 12:15 p.m., FM AA was asked to clarify about R65 feeding themselves and said they could only feed themselves if something was placed in R65's hand and they were assisted. FM AA said at that time R65 had good range of motion in both arms prior to their injury and denied contractures being present. On 3/25/26 at 2:13 p.m, the DON was asked about R65's missed orthopedic appointment yesterday. The DON said the transportation company was late and the orthopedic surgeon could not see R65 after their appointment time. The DON said they were using a newer transportation company. Review of R65's tasks tab in the medical record for transfers showed there was no lift transfer completed at or near the time of R65's injury, on 3/08/26. On 3/25/26 at approximately 3:50 p.m., the concerns regarding R65's avoidable injury were shared with the Nursing Home Administrator (NHA) during the Quality Assurance and Performance and Improvement interview. The NHA said they understood the concerns, denied any intentional abuse had occurred from their own investigation, and conveyed they had personally reviewed the video footage from the date of the incident, 3/08/26, and had found no lifts going in or out of R65's room, no fall had occurred and there were no unusual observations. On 3/25/26 at 4:00 p.m., the NHA shared the facility had a Past Non-Compliance (PNC), when a deficient practice was identified on 3/08/26, related to R65's fractured right arm, which had occurred during care. The PNC was received just prior to survey exit. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included identification of the deficiency, review of the facility residents for similar concerns, staff education, one-to-one education for CNA BB, and appropriate (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	monitoring. The facility was able to demonstrate monitoring of the corrective action and maintained compliance during the survey.Review of CNA BB's reeducation, dated 3/16/26, revealed, During routine care on 3/09/26, the resident (R65) sustained a fracture to the right arm; the care was consistent with the resident's needs at that time. Reeducated on safe handling and transfer techniques including use of slow, controlled movements, cues of pain or discomfort. Recognize that residents with osteoporosis, contractures, or frailty are at increased risk for injury even with appropriate care. Anticipate fragility. Adjust care techniques in real time. Review of the policy, Pain Management, revised 4/01/24, revealed, The policy will evaluate and identify residents for pain, determine the type, location, and severity and develop a care plan for pain management.Acute pain refers to pain that is usually sudden in onset and time limited with duration of less than 1 month and often is caused by injury, trauma, or medical treatments such as surgery. Review of the policy, Incidents and Accidents, revised 7/08/25, revealed, Policy; Incident or Accidents involving a resident will be documented and reported so as to meet regulatory requirements. The Administrator and the Director of Nursing will be notified as outlined in this policy. Definitions: Incidents Requiring Further Investigation - Injuries of Unknown Origin.8. All Incident and Accident reports are reviewed by the Administrator or Director of Nursing. There was nothing about prevention of injuries of unknown origin. This policy focused on documentation requirements and how to investigate the incidents.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. This citation pertains to intake #'s 2741968, 2679285 and 2694463. Based on observation, interview and record review, the facility failed to ensure sufficient Nurse staffing levels to meet resident needs for three residents (R13, R48, R74 and R102) and multiple anonymous residents that participated in the group meeting of a total census of 106, resulting in long wait times for staff assistance and delay in medication administration and treatments. Findings include: Resident Group Interview: On 3/24/26 at 11:00 AM, a confidential resident council interview was conducted with eight residents that normally attend the resident council meetings. When asked about if they got the help and care they needed without having to wait a long time and if staff responded to their call light timely, eight of eight residents verbalized concerns. Their responses included: Last night in our wing, we didn't have a Nurse until 12:00 AM. The day nurse was here all day. So when they are late with medication, what are we supposed to do? Double up? That's a big problem. They sit and talk at nursing station I know cause I have to find the nurse to pass the medications. They will be there yapping away. I haven't had my morning meds yet. My pain patch is supposed to be given between 9:00 AM and 10:00 AM. Three additional residents reported they also had not received their 9:00 AM medication. It's an issue for both floors. Had to wait over two hours. When I ask why they waiting so long and they give me attitude back. Wait sometimes 20, 30, 40 or 50 minutes at times. I have to tell my roommate hit your button and I'm going to grab someone. They say I'm coming but it's not for 30 more minutes. When I say my buttons been on for two hours, it's been on for two hours. Why would I lie? The clock is right in front of my face. I can go up across the hall and up to nursing station and they are talking and laughing and ignoring. That's after waiting an hour. On 3/23/26 at 9:12 AM, R48 was observed sitting in a wheelchair in his room. R48 was asked about care at the facility. R48 explained there was not enough staff. R48 was asked what happened when there was not enough staff. R48 explained there was long call light response times, averaging 1 to 1 1/2 hours due to not enough staff, housekeeping only cleaning his room every other day, or every third day due to not enough housekeeping staff, laundry was supposed to be delivered the next day after being sent down, but he still did not have his laundry he had sent down on 3/20/23 due to not enough laundry staff. On 3/24/26 at 10:18 AM, R48 explained the day shift nurse had to stay to pass the evening medications the night before because there was no one to relieve her. When asked how often that (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	happened, R48 explained a couple times a month the residents do not get their night medications until morning due to there being no nurse on the unit. On 3/25/26 at 10:25 AM, LPN 'E' was interviewed and asked about staffing in the facility. LPN 'E' explained it had not been good lately, there used to be three nurses on the 1st floor, now there were only two nurses and four to five CNA's. LPN 'E' was asked if two nurses and four to five CNA's was enough staff to care for the residents' needs. LPN 'E' explained she did not think it was. LPN 'E' was asked what did not get done. LPN 'E' explained treatments get done late, if at all, because the floor nurse had to do them all, there used to be a treatment nurse that did the treatments, but now the floor nurses had to do the treatments. When asked if there were Unit Managers, LPN 'E' explained there was one for the 1st floor and one for the 2nd floor, but they often had to work on the floor so they could not help if they were working on the floor themselves. On 3/25/26 at 10:01 AM, LPN 'J' was interviewed by phone and asked about staffing in the facility. LPN 'J' explained staffing had been poor lately. LPN 'J' was asked how many nurses were usually scheduled. LPN 'J' explained usually there were four nurses scheduled, two for each floor. LPN 'J' was asked if there were ever only three nurses scheduled. LPN 'J' explained it had happened a couple of times, but she had told them she could not split the building like that, with the nurses covering two floors. Cross Reference: F600 R48 On 03/23/2026 at approximately 9:12 a.m., R48 was observed sitting in their wheelchair. R48 was asked if they had any concerns and reported there are not enough staff and it takes tong for staff to answer the call button. R48 indicated it takes 1 to 1.5 hours average for staff to respond and provide assistance. R74 On 03/23/2026 at approximately 11:07 a.m., R74 was asked if they had any concerns regarding their care and they reported that did not have a Nurse the previous day (Sunday-3/22/26) until 11:00 AM. R74 indicated there was confusion about what Nurse who was supposed to have been coming in and they missed their morning medications. R74 indicated that staffing has gotten worse since the beginning of the year as they indicated they thought that management was sending staff home that are needed to help the residents. R74 reported that one Nursing aide for the whole hall was not enough. R13 On 03/23/2026 at approximately 10:10 a.m., R13 was observed in their room, lying in their bed, R13 was asked if they had any concerns regarding the staffing levels in the facility and they reported they need more staff because they experienced long call light response times, especially in the afternoon shift. R102 On 03/23/2026 at approximately 12:52 p.m., R102's family member was asked if they had any (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concerns regarding the care of their loved one and they reported that R102 did not use the call light anymore because there are not enough staff to answer it. They reported that R102 had fallen over the weekend in attempting go to the bathroom. On 03/25/2026 at approximately 1:59 p.m., Staffing Coordinator B (SC B) was queried regarding staffing levels in the facility. SC B indicated that they staff the building according to the PPD (patients per day) levels set by their corporate office. SC B reported indicated that the facility has been short staffed and they were aware of staffing shortages. SC B reported they had about five Nurses recently resign and were trying to hire more but the facility does not permit them to use agency Nurses or hire PRN (contingent/as needed) Nurses to fill the shortages. SC B reported that when multiple Nurses take leave, it is difficult to staff Nurses appropriately. SC B reported they utilize an application to notify all staff of open shifts. SC B was asked if they take into consideration the acuity levels of the facility residents and they reported they do not and that the Nursing mangers are supposed to adjust for acuity levels. SC B was asked if they were aware of the issues that being short staffed had affected the residents and they indicated that they were aware of meal tray passes being late due to staffing problems. SC B reported that hiring more Nurses will help with the staffing difficulties the facility had been experiencing. On 3/25/26 a facility document titled Nursing Staffing was reviewed and revealed the following: Policy-The nursing services department provides 24-hour nursing services.The facility ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well* being of each resident, as determined by resident evaluations and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Information Nursing service is provided by number and type of personnel to ensure that each resident: Receives treatments* medications, and diets as prescribed; Receives rehabilitative nursing care as needed; Receives proper care to maintain their highest level of functioning (prevent decline in function or poor clinical outcomes); Is kept clean, comfortable, and well-groomed. Is protected from accidents, injury, and infection; and is encouraged* assisted and trained in self-care and group therapy 4. A licensed nurse (RN or LPN/LVN) is on duty for each shift (tour of duty) and is responsible for providing direct nursing care as well as supervising non-licensed nursing personnel. A person shall not be assigned to duty on the night shift if that person has been on duty either in the home or any other place of business during the preceding 8 hours, but may assume temporary duty on the night shift if the facility has made every reasonable effort to otherwise eliminate a staffing emergency, 5. Work assignments are prepared by the nursing supervisor or charge nurse and issued on a daily basis. 6. Nursing assistants are expected to carry out their daily assignments in a professional manner and in accordance with established nursing procedures. 7.The nursing supervisor or charge nurse must approve all changes in work assignments. 8. Nursing staff will meet competency requirements based on the number of residents, resident acuity, range of diagnoses, and the content of the individual care plan. 9.The facility will staff to meet the needs of the residents at the facility. 10. Refer inquiries concerning nursing services to the Director of Nursing

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interview and record review the facility failed to ensure that the medication error rate was less than five percent with a percentage of 6.45. Findings include: On 3/23/26 at 9:18 AM, a medication administration pass was completed with Registered Nurse (RNHH). RNHH was observed pulling medications from the pack and administered Lasix 20mg(milligrams), multivitamin, MiraLAX 17 g(grams) Duloxetine 60 mg, allopurinol 100 mg, carvedilol 3.125, vitamin B12 and lisinopril 5 mg.On 3/23/26 at 12:38 PM, a review of the medical administration record was made and the following errors were discovered. Duloxetine 60 mg was ordered as DULoxetine HCl Capsule Delayed Release Particles 60 MG Give 1 capsule by mouth at bedtime for depression. It was ordered to be given at bedtime and was giving during the morning medication pass. There was also an order for Famotidine Oral Tablet 20 MG Give 1 tablet by mouth one time a day for GERD (Gastro Esophageal Reflux Disease) IN THE MORNING and it was not observed being given but was signed off on the medication administration record as being administered.On 3/23/26 at 1:10 PM an interview with the Director of Nursing (DON) and she was made aware of the medication observation pass and the errors that were made. The DON reported that she would follow up with the nurse and have them fix the situation.There was no additional information provided.

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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. This citation pertains to Intake #2694463. Based on observation, interview and record review, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), failed to ensure infection control standards and practices were consistently implemented by the facility staff and failed to implement an effective infection control surveillance program. This deficient practice has the increased potential to result the in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility and the spread of infection to residents. Findings Include:On 03/23/26 at 11:50 AM observed a functional hopper in soiled laundry sorting room. When the hopper faucet was turned on, discolored water ran for a few seconds before running clear. On 03/23/2026 at 2:05 PM an interview with Assistant Maintenance Supervisor (AMS) A found the Maintenance Director left suddenly two weeks ago. On 03/23/2026 at 2:06 PM observed one boiler at 128 degrees F and the second boiler at 122 degrees F in the boiler room. On 03/23/2026 at 2:09 PM an interview with AMS A found there is no water management team to their knowledge, and they were not involved in the water management plan as the assistant and were unsure of the maintenance director's responsibilities regarding the plan. When asked about flushing, AMS A indicated they flushed tubs, hoppers, and eyewash stations once a week. When asked about the hopper in the laundry room, AMS A indicated that was not a part of their flushing routine. On 03/23/2026 at 2:39 PM an interview with AMS A regarding documentation of flushing found they do not keep logs, and flushing is done weekly when it notifies them on their maintenance system TELS. On 03/23/2026 at 3:26 PM an interview with Nursing Home Administrator (NHA) found the water management team previously consisted of the NHA, Director of Nursing, Infection Preventionist and Maintenance Director. The NHA stated that the AMS A was now assuming those responsibilities. NHA stated they had recently sent out a legionella training resource to the team to get them up to date. When asked when the last time was that they had a formal meeting to discuss water management, NHA stated that they need to meet. It was noted that the last minutes were dated 2024 and no documentation of a 2025 meeting, NHA did not dispute. When quired about additional documentation related to water management, NHA indicated they had no other documentation. Record review of a facility provided binder entitled Legionella Environmental Plan included a document Legionella Environmental Assessment Form with a date of assessment marked 9-1-2025. Question 18 asked Does the facility have a water management program (WMP)? The box was checked yes, and the form states: If YES, please describe the program briefly here (does it include clinical disease surveillance and/or environmental Legionella surveillance?) and obtain a written copy of the program policy: with a response marked See attached copy of policy. Question 28 asked How is the hot water system configured to deliver hot water to each building? Below usual temperature setting, 150 degrees F was written indicating the temperature each boiler is set to. Record review of a facility provided binder entitled Legionella Environmental Plan included a map titled Notting Hill Evacuation Routes including Green dot water/showers sinks indicated at various (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	points in the map. A flow diagram of water and description of water traveling through the facility was not present in the binder. Record review of a facility provided binder entitled Legionella Environmental Plan included a policy titled Water Management Program last revised 2/1/2024. Including: Developing and maintaining a water management program is a multi-step process that requires continuous review. Seven key activities are routinely performed in a Legionella water management program: Establish a water management program team Describe the building water systems using flow diagrams and a written description Identify areas where Legionella could grow and spread Decide where control measures should be applied and how to monitor them Establish ways to intervene when control limits are not met Make sure the program is running as designed (verification) and is effective (validation) Document and communicate all the activities The general principles of an effective water management program include: Maintaining water temperatures outside of ideal range for Legionella growth Preventing water stagnation Ensuring adequate disinfection Maintaining devices to prevent sediment, scale, corrosion and biofilm, all of which provide habitat and nutrient for Legionella growth. The water management program team will meet quarterly in conjunction with the infection control committee to validate and verify the water management program utilizing the meeting minutes for the water management program. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Hot water: Store hot water at temperatures above 140 degrees F (60 degrees C). Ensure hot water in circulation does not fall below 120 degrees F (49 degrees C). Recirculate hot water continuously, if possible. On 3/23/26, the infection control preventionist (ICP) JJ was interviewed to review the facility's Infection Control and Surveillance program. When asked if the facility had any recent outbreaks or any trending infections, ICP JJ reported that the facility did not have any recent out breaks. A review of the facility's infection control surveillance program revealed that the program was not on-going/continuous and was a month behind. ICP JJ was asked about the line listing and how did they follow trends if the list was not completed. The type of infection, duration of treatment, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	location was not provided on the line list. McGreer's criteria was not provided/implemented. ICP JJ reported that the facility had completed a Past noncompliance for December 2025 and January 2026. A review of the infection control books was conducted and ICP JJ was asked for several residents, where the laboratory results could be found, the clinician's rationale for the use of antibiotics were and where could the McGeer's criteria be found for the use of antibiotics. The material requested was not available for review. ICP JJ reported that they had worked on the books and tried to keep them up to date however, by them working as a floor nurse (due to staffing shortages) the program was still non compliant except for the month of February when the staff was not challenged and they were able to do their hired job. ICP JJ stated they were not offered any assistance or support to complete their job responsibilities. ICP JJ also reported that they had reached out to corporate staff to get additional help and training but was denied due to them being done with orientation. ICP JJ reported that since the time of hire they had been more of a floor nurse than an ICP. There was no additional information provided by the exit of survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235663	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notting Hill of West Bloomfield	6535 Drake Rd West Bloomfield, MI 48322

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to develop an antibiotic stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. Findings include:On 3/23/26 an interview was conducted with Infection control preventionist (ICP) JJ. They were asked to explain the facility's antibiotic stewardship program. ICP JJ reported that they make sure that residents meet McGeer's criteria, make sure staff are following protocol and procedures, educate staff on the importance of following infection control policies, and utilize audits and an infection screening tool that they use to interview patients to see if they meet criteria. ICP JJ was asked when they started in their position and reported that they started in November of 2025 and was hired for strictly Infection control, but the staffing was not the best at the facility so they had been working as a floor nurse and doing infection control when they could or had time. ICP JJ also reported that the facility had completed a Past noncompliance for December 2025 and January 2026. A review of the infection control books was conducted and ICP JJ was asked for specific resident laboratory results could be found, the clinicians rational for the use of antibiotics and where could the McGeer's criteria be found for the use of antibiotics they were prescribed. The material requested was not available for review. ICP JJ reported that, they had worked on the books and tried to keep them updated however, by them working as floor nurse due to staffing shortages, the program was still not compliant except for the month of February when staffing was not challenged, and they were able to do their hired job. ICP JJ also reported that they had reached out to corporate staff to get additional help and training but was denied due to them being done with orientation. ICP JJ reported that since the time of hire they had been more of a floor nurse than an ICP.A request for the antibiotic stewardship policy was requested, and no additional information was provided.