STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Village of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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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 has two deficient practice statements (DPS).DPS #1 Based on observation, interview, and record review, the facility failed to prevent a fall with significant injury for one (R39) of two residents reviewed for falls, which resulted in a head injury, sutures, and ongoing pain and discomfort. Findings include: On 12/02/25 at 11:55 a.m., R39 was observed lying on their back in their bariatric hospital bed. Enabler bars were observed on both sides of their bed. The bed was mid-height. Large crescent shaped bruises were observed under their eyes. On 12/02/25 at 11:58 a.m., R39 reported they fell out of their bed about a week prior and hit their head on the floor. R39 stated they rolled out of the hospital bed in the night, hit their head on the floor, and had to go to the hospital to get stitches. R39 said their bed was about mid-height and explained their mobility bars were taken off their bed by facility staff, which they had used for safe bed mobility (rolling). R39 clarified they had ongoing pain in the back of their head since the falls, and they felt the mobility bar would have prevented the fall, as they used it for bed mobility (rolling). R39 shared they had asked staff for new bars, as they felt unsafe when being rolled during cares, and had worried about falling out of bed prior to the incident. Review of R39's ADL (Activities of Daily Living) Care Plan, revised 10/20/25, prior to their fall, revealed they required one-person extensive assistance for bed mobility, although sometimes they could perform bed mobility by themselves per the Care Plan. Review of R39's Kardex (Nurse Aide Care Directive), accessed 12/04/25, revealed R39 needed a wider bariatric bed to assist them with turning and positioning, one-person extensive assistance with bed mobility (it was noted the mattress was replaced immediately same day of fall), and bilateral assist bars to assist R39 with positioning while in bed. Review of R39's profile sheet, accessed 12/04/25, revealed they were their own responsible party. Review of the Electronic Medical Record (EMR) showed R39 was admitted to the facility on [DATE], with diagnoses including osteoarthritis, sciatica (nerve pain traveling from the back down their legs), history of falls, lung disease, morbid obesity, depression, and adjustment disorder with anxiety. Review of R39's physician orders, accessed 12/04/25, revealed, bilateral assist bars to aide in (bed) mobility, initiated (active order) 10/17/24. It was noted the order was never discontinued and remained current during their stay. Review of R39's Care Conference Summary, by facility Social Worker E, dated 10/14/25 at 2:49 p.m., revealed, .(R39) does not like (their) bed and (their) assist bars are missing. Writer will complete concern form. It was noted R39 fell out of bed without assist bars on 11/19/25, over one month after R39 raised concerns. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R39's grievances, provided by the facility, revealed no grievances related to bed mobility or mobility bars, when requested via email twice. Review of R39's weight logs revealed R39 weighed 282 pounds on 11/05/25, the last facility weight obtained by the facility near the time of their fall. On 12/04/25 at 10:11 a.m., the Rehabilitation Director, Certified Occupational Therapy Assistant (COTA) J, and Physical Therapist, (PT) T, reported they had been attempting to obtain new bedrails for R39's bariatric hospital bed when R39's fall out of bed occurred. On 12/04/25 at 10:50 a.m., R39 reclarified they had a bariatric bed prior to their fall; however, it was not wide enough. R39 reported they had told nursing staff who assisted them they were afraid of rolling out without the bedrails which had been taken away, and they had not understood why. R39 reported the wide bariatric bed they currently were using was provided after they fell out of bed on 11/19/25 and said the bedrails (enabler bars observed) came with the new bed, which were observed. Review of R39's progress note, dated 11/20/25 at 10:14 a.m., showed the root cause of the fall, which said R39 rolled out of bed during a dream. This note further revealed, .Staff noted issues with (R39's) current mattress and immediately replaced the mattress.New interventions: New wider bed and mattress It was noted the mattress was defective when R39 fell out of bed. Review of R39's nursing progress note, dated 11/20/25 at 1:26 p.m., showed, (R39) observed laying on the floor on her right side next to the bed around 2010 (8:10 p.m. – on 11/19/25). Abrasion on right forehead with minimal bleeding noted on the floor. 911 called and took resident to hospital. Review of R39's progress note, dated 11/20/25 at 5:58 (a.m.) showed, .Event occurred at 11/19/2025. 8:10 p.m. Resident returned to facility at around 0440 (4:40 a.m.) transport via (Company name) ambulance. Bandage on resident forehead noted. Review of R39's progress note dated 11/20/25 at 18:54 (6:54 p.m.), revealed, First day post fall for resident.(R39) did complain (of) headache and back ache. (R39) was given prn (as needed) Norco (narcotic pain medication).(R39) did complain of second headache in PM (afternoon) and given Motrin (non-narcotic pain medication) for headache. Review of R39's nursing post fall documentation note, dated 11/23/25 at 6:29 (a.m.), revealed, Date of fall: 11/20/2025.Injuries: Bruising to face with 4 sutures.Follow-up/subsequent communication: (left blank). On 12/04/25 at 11:38 a.m., Licensed Practical Nurse, (LPN) S, was called as they worked on 11/19/25 on the midnight shift and completed the Accident report documentation and a progress note. No call was returned by survey exit. Review of R39's Accident and Incident report, by LPN S, dated 11/19/25 at 22:10 (10:10 p.m.) revealed, .Immediate Action Taken: Resident mattress on bed replaced; wider bed/mattress ordered.Level of Pain: 5 (of 10, with 10 the highest pain). Review of R39's grievances provided by the facility upon request revealed no grievances respective to R39 requesting mobility bars or a wider mattress, as described in SW E's progress note. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R39's Hospital After Visit Summary, dated 11/20/25, revealed a diagnosis of head injury adult.Fall: Laceration of forehead.Injury of head. The summary revealed R39 was 5'1 tall and weighed 313 lb (pounds), 11.4 oz (ounces), significantly more than their last facility weight of 281 pounds on 11/05/25. On 12/04/25 at 11:47 a.m., the Unit Manager, LPN H, who had completed some of the post-fall documentation, was asked about the Root Cause of R39's fall out of bed on 11/19/25, when R39 was sent out emergently, and returned to the facility on [DATE]. LPN H confirmed R39 did not have mobility bars on their bed when they fell out of bed on 11/19/25. LPN H clarified the mobility bars did not fit their bed so they were removed and said therapy was working to try to find assist bars which were compatible with R39's bed when they fell out of bed. LPN H continued the facility ordered R39 a new, wider bariatric bed with attached rails after R39's fall out of bed with injury (sutures) and increased pain. LPN H concurred R39's fall would have been avoidable had they received the proper bed prior, as a bariatric bed with attached rails was found and provided to R39 after they fell of their bed on 11/19/25. On 12/04/25 at 11:52 a.m., LPN H was asked if R39 should have had assist bars on their bed when R39 fell out of bed on 11/19/25 and responded, Yes. LPN H was asked about R39's mattress being replaced per facility documentation immediately after R39's fall with injury out of bed. LPN H confirmed R39's midnight nurse, LPN N, had reported to them R39's mattress had malfunctioned and deflated on one side, which contributed to R39's fall out of bed, and confirmed the air mattress was defective. LPN H also confirmed R39 had sutures on their head after they fell and had increased pain after the fall but said they were not aware they were still having headaches after their fall. Review of R39's Medication Administration Record (MAR) for the month of November 2025 revealed six of seven days they received narcotic (opioid) prn (as needed) pain medication after their fall on 11/19/25. LPN H concurred after record review with Surveyor this was not typical for them, and this was more narcotic pain medication than R39 usually received. On 12/04/25 at approximately 2:00 p.m., Surveyor reviewed concerns related to R39's fall out of bed with the Nursing Home Administrator (NHA). The NHA reported they had been aware R39 needed new assist bars and the wrong assist bars came, per the Rehab Director, COTA J. Surveyor conveyed concerns were also related to R39 wanting a wider mattress, expressing fearfulness during turning and cares on their prior mattress, and facility documentation and interviews showing their mattress malfunctioned when they fell, and was replaced after their fall with injury. Surveyor also reviewed concerns related to increased pain and R39 requiring sutures after they fell. The NHA conveyed they had worked on getting R39 alternate rails but were not made aware of bed concerns and R39's increased pain. The NHA acknowledged they did not fully investigate the incident, and had no witness statements or other investigation available, other than the progress note with RCA and the Accident and Incident report and progress notes. The NHA had no additional comment at that time. Review of the policy, Incident Reporting – Accidents and Supervision, Revised 8/24, revealed, Policy: The resident environment remains as free of accidents hazards as is possible, and each resident receives adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring effectiveness and modifying interventions when necessary. Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. 1. Identification of Hazards and Risks – the process through which the facility (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. All staff (e.g. professional, administrative, maintenance) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident. c. Various sources provide information about hazards and risks in the resident environment.2. Evaluation and Analysis. The process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. a. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc. b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. c. Evaluations also look at trends such as time of day, location, etc 3. Implementation of Interventions – using specific interventions to try to reduce a resident's risks from hazards in the environment. 4. Monitoring and Modification – Monitoring is process of evaluating the effectiveness of care plan interventions and making modifications. 5. Supervision – Supervision is an intervention and a means of mitigating accident risk. The faciltiy will provide adequate supervision to prevention accidents. Adequacy of supervision: a. defined by type and frequency. 6. Documentation. The purpose of the Incident/Accident report is to provide a standardized, systematic process to ensure that all accidents and incidents are promptly identified, reported and investigated and that measures addressing causes are implemented to prevent recurrence. An Accident/Incident report is any situation that involves harm or potential harm which is outside the usual or expected. These include: but are not limited to: a. Falls (any unintended movement from one surface to a lower surface).g. Unsafe Conditions. DPS #2 This citation pertains to intake #2640057. Based on observation, interview and record review, the facility failed to ensure an environment free from accident hazards related to resident smoking and storage of smoking paraphernalia for two (R26 and R46) of three residents reviewed for smoking. Findings include: Review of a complaint submitted to the State Agency included allegations that R26 was smoking in their room and staff are overheard talking about R26's smoking in the facility and a resident was told by staff that R26 does what he wants and that the administrator is aware of the issue but felt nothing had been done and they did not feel safe. According to the facility's policy titled, Resident Smoking dated 2/25:It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents .Smoking is prohibited in all areas except the designated smoking area.Residents who smoke will be further assessed to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all Electronic cigarettes (e-cigarettes/vape/vapor pen) can catch on fire and/or explode if not handled and stored safely.Use of e-cigarettes in designated smoking areas only.Don't use the device around flammable gasses or liquids, such as oxygen.Loose e-cigarette batteries and extra cartridges will be stored away from coins, keys, or other metal objects.Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(weather permitting), at designated times, and in accordance with his/her care plan.If a resident or family does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures.Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. On 12/2/25 at 9:42 AM, R26 was observed seated in a motorized wheelchair in room, wearing winter jacket and hat. An ashtray with ashes was observed on a table near the resident's dresser and a pack of cigarettes. When asked about the smoking materials, R26 reported they smoked cigarettes and kept the cigarettes and lighter on themselves. When asked where they smoked, R26 reported they usually went outside but also stated I do smoke in my room I won't lie to you. When asked if anyone had addressed the safety concerns with smoking in the facility, R26 acknowledged they had but further reported they had been in prison for 34 years and don't like locked doors. On 12/2/25 at 11:55 AM and 12/3/25 at 9:00 AM, the pack of cigarettes and ashtray remained on the table in the resident's room. Review of the clinical record revealed R26 was initially admitted into the facility on 9/13/23 and readmitted on [DATE] with diagnoses that included: nicotine dependence unspecified uncomplicated. According to the annual Minimum Data Set (MDS) assessment dated [DATE], R26 had no communication concerns, had intact cognition, and exhibited no mood or behavior concerns during this assessment period of seven days. Review of the care plans as of 12/2/25 included several non-compliance care plans, including one for smoking that documented: Smoking: I have been assessed by the IDT (Interdisciplinary Team) and I am allowed to smoke/able to smoke independently, I have a potential for injury related to smoking there are times when I will not give my smoking paraphernalia to staff. I have been educated on following smoking policy. I choose to smoke in my room while in bed. I have been educated on smoking policy LOA (Leave of Absence) process and I choose to not follow this policy I will sit at the front entrance and smoke in non-designated smoking area. This was initiated 2/26/25 and most recently revised on 10/17/25 by Nurse 'E'. Interventions included: I will allow staff to search my room if staff smell cigarette smoke and remove them <sic> my room. Initiated 4/18/25 by Social Services Manager (SS 'F'). Document any behaviors related to not smoking on my behavior task/progress note. Initiated 2/26/25 by Nurse 'E'. Smoking paraphernalia will be stored at the nurse's station. Initiated 2/26/25 by Nurse 'E'. There were no interventions identified/implemented on how to specifically address the resident's (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	non-compliance with smoking in the room. It should be noted that additional interventions were implemented on 12/3/25 after concerns were identified during the survey. Further review of the clinical record revealed multiple progress notes of R26 found smoking in their room, including while in bed. The facility's responses to some of these instances included documentation that the resident had been re-educated and provided with copies of the facility's smoking policy. There were no other interventions identified within the clinical record and in accordance with facility policy which addressed the resident's continued non-compliance and/or identified what other safety measures had been implemented following these multiple smoking incidents in the facility. Documentation of the progress notes included: An entry on 11/19/25 at 10:42 AM by Nurse Manager (NM 'H') read: .discussed resident in risk.Resident noted smoking in his room he was reissued a copy of smoking policy and informed he is expected to adhere to policy at all times. An entry on 11/13/25 at 7:25 AM by Physician 'L' documented, in part: .The patient was evaluated today for a routine regulatory assessment. He is alert and cooperative, able to follow commands, and oriented to person and place. He is electric-wheelchair dependent due to a left above-knee amputation (AKA) and chronic right lower-extremity (RLE) contracture.Chart review reveals a pattern of non-compliance, including.smoking in his room, both documented repeatedly by nursing. Patient was again counseled on smoking cessation, fire risk.Plan.Smoking prohibition reinforced. An entry on 11/9/25 at 7:54 PM by Nurse 'B' read: Writer observed resident smoking in room. Writer educated the resident on the risk of smoking inside room. Resident still noncompliant. Writer asked resident multiple times to put the cigarette out resident refused. An entry on 9/8/25 at 9:26 AM for 9/4/25 at 00:00 by Nurse Practitioner (NP 'O') read: .Patient was seen today for regulatory visit. Patient today alert and following commands. He is electric wheelchair bound.Patient notes reviewed, showing non-compliance, refusing medication and smoking in room. Patient educated on importance of smoking cessation. Patient and nursing staff without any other concerns at this time An entry on 9/2/25 at 5:25 AM for 9/1/25 at 21:10 by Nurse 'P' read: .Resident was observed smoking in the room and was instructed not to smoke in the room because of the risk it might cause fire, resident became very angry yelling, cursing at the nurse using profanity. Resident refused to give the cigarette and lighter to the nurse, DON and administrator were both notified by phone . There was no additional follow-up documented in the clinical record following this incident. A care plan note on 8/29/25 at 10:23 AM by Nurse 'E' read: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	.Focus: Smoking: I have been assessed by the IDT and I am allowed to smoke/able to smoke independently, I have a potential for injury related to smoking there are times when I will not give my smoking paraphernalia to staff. I have been educated on following smoking policy. I choose to smoke in my room while in bed. I have been educated on smoking policy LOA process and I choose to not follow this policy I will sit at the front entrance and smoke in non designated smoking area. Effective Date:8/29/2025. An entry on 7/15/25 at 7:58 AM by Nurse 'Q' read: .Staff alerted writer that resident was smoking in bed again. Writer educated resident on the dangers of smoking in bed. He said he dose <sic> not care and is careful. Writer did convince resident to put that cigarette out. An entry on 7/12/25 at 6:38 AM by Nurse 'P' read: .Resident was smoking in his room and was instructed to stop smoking in the room, then resident became angry, loud using profanity and was still smoking and said no body can do him anything. DON and administrator was notified and resident was closely monitored until he stop smoking. An entry on 7/11/25 by Nurse 'Q' read: .Resident was smoking while in bed. Resident was educated on the risk of smoking in bed and he refused to put out cigarette. An entry on 7/11/25 at 11:11 AM by SS 'F' read: .Writer met with resident. Resident stated he is good.No psychosocial concerns at this time. There was no documentation the social worker had been informed of the resident's continued behaviors of smoking addressed and/or documented. An entry on 7/11/25 at 4:51 AM by Nurse 'R' read: .Resident smoked in his room, when confronted, he said I feel like smoking and I cannot go outside now. An entry on 6/24/25 at 6:56 AM by Nurse 'P' read: .Resident was caught smoking in the room and was instructed not to smoke in the room and explained to resident of danger of smoking in the room. Resident became very agitated using profanity and said we cannot do him <sic> anything. DON (was notified by phone and instructed to make sure we collect the cigarette and the lighter from him, but resident refused and said he does not have cigarette or lighter with him.Resident was in bed in the room. On 12/3/25 at 11:53 AM, an interview was conducted with SS 'E'. When asked about who conducted with resident's smoking assessments, SS 'E' reported that would usually be nursing or activity staff. When asked if they had been notified this week of any concerns with smoking paraphernalia for R26, SS 'E' reported they had not. They further reported R26 was non-compliant with smoking and reported they had recently been seeking alternate placement. When asked if resident should have any smoking paraphernalia on them, SS 'E' reported all smoking materials should be locked up, including vapes and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	further stated Everything should be locked up. When asked if they were aware R26 had an ashtray in their room and had been observed since the first day of the survey, SS 'E' reported they did not. At that time, SS 'E' was requested to accompany to R26's room. On 12/3/25 at approximately 12:00 PM, SS 'E' approached R26 and confirmed the ashtray in the resident's room. When asked about what safety measures had been implemented following the multiple incidents of R26 smoking in their room, including while in bed, SS 'E' reported they always explained risk verse benefit and explained we have oxygen in the building and putting everybody at risk of being blown up. They reported they were actively looking for alternate placement for the resident.On 12/3/25 at 12:25 PM, an interview was conducted with the Administrator. When asked about whether residents were allowed to keep smoking paraphernalia on themselves, the Administrator deferred to their smoking policy and further reported those items were kept locked on a smoking cart managed by the Activity Director. When asked if they were aware of any residents not following the facility's smoking policy, the Administrator reported they began at the facility end of December last year and took over on June 30, 2025. They further reported that for about three weeks or so they had been working with their legal and corporate team to work on a discharge plan for R26. They were not aware of any other residents that had smoking paraphernalia. The Administrator was informed that during the survey, there was an additional resident observed with this and also reported that they smoked in their room as well. The Administrator reported they were not aware of that. When asked other than re-issuing a copy of the facility's smoking policy and encouraging smoking cessation after each occurrence, what was being done to address the safety concerns, the Administrator reported finding alternate placement. It should be noted that after this concern had been brought to the facility's attention during the survey, the facility implemented a staff person for R26 on a one to one basis for increased supervision. However further review of the progress notes included an entry on 12/3/25 at 8:57 PM by Nurse 'A' that read, .At about 1900 (7:00 PM) the CENA assigned to resident for 1:1 notified writer that resident was bringing a bottle of liquor, a lighter, and a cigarette out of his drawer and attempting to light a cigarette. R46 Clinical record review revealed R46 was admitted to the facility on [DATE] with a history of schizophrenia, substance abuse, and was a current smoker. Clinical record review of the Safe Smoking assessment dated [DATE], evaluated R46 may smoke with supervision. R46 had a self-care performance deficit related to bilateral above the knee amputations and used a wheelchair. A Brief Interview Mental Status assessed on 10/20/25 scored 15/15 indicating R46 was cognitively intact. On 12/2/25 at 10:32 AM, R46 was observed lying in bed parallel to a wall with a large sliding window. The sill of window was observed as personal storage area containing pictures of nude women, a purple vape pen, a cigarette with brown colored filter, and a package of Zig-Zag papers (brand of rolling papers for hand rolling tobacco). On 12/2/25 at 12:40 PM, when asked how they get outside to smoke, R46 replied I don't go outside. When asked how they smoked, they replied they could open the window and smoke from their bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	When asked if this was performed because of how cold it is outside, R46 replied it was not due to the weather, they just don't like to go outside. A purple vape pen, cigarette with brown colored filter, and package of Zig-Zag paper remained in reach at bedside windowsill. On 12/3/25 at 9:08 AM, the package of Zig-Zag papers remained at bedside. On 12/3/25 at 10:09 AM, R46 was observed in a wheelchair wearing a winter style coat, waiting near exit to smoking area and was observed holding what appeared a hand rolled cigarette. On 12/3/25 at 1:12 PM, the Nursing Home Administrator was informed of the findings and comments made by R46. Per the NHA, smoking paraphernalia is not to be stored at bedside. When asked why after multiple observations of the paraphernalia, why it remained at bedside. The NHA acknowledged staff should have removed and locked in the smoking box.

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	235664	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Village of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, clean, homelike environment resulting in odors (R42) and equipment that does not work properly. Findings include:Findings include: 12/02/2025 08:40 AM -Initial entrance into the facility starting at room [ROOM NUMBER], the entire corridor profoundly smelled of urine. On 12/3/25 at 9:00 AM, the social room with vending machine, was observed with the entire floor including perimeters of room was unkempt giving the appearance the floor was not cleaned. Popcorn and kernels were observed on scattered across the floor. Five of six floor vents were observed with moderate amounts of accumulated dust and dead insects. The six-floor vent located to the right of the exit door was corroded with black grime and rusted into the tile flooring. The windowsills were dusty and multiple dead insects were lying inside the interior window tracts. The blinds hanging from the window closest to the television were bent, broken and being held up by a plastic frame-like object. Three cardboard boxes were observed pushed into the corner of the floor storing books and magazines. The floor vented outside of rooms [ROOM NUMBERS] were observed with hairlike debris entangled in the grate and moving when the heat was on. On 12/3/25 at 9:35 AM, an interview with Rehabilitation Manager (RM) J was asked who maintains the cleaning of the floors and equipment, RM J acknowledged housekeeping is responsible for the floors and equipment is maintained by the rehab staff and cleaned in between resident use. While observing the room, in front of the SCIFIT Recumbent Stepper (exercise machine) a pile of black colored ash like dust was collected in front of a dirty rusted floor vent. The SCIFIT foot pedals and heel cups of (oversized foot beds with safety edges) were observed to contain moderate amounts of a [NAME], crumb like debris. A portable cylinder oxygen tank was stored next to the equipment covered in dust and insect webs. All three of the floor vents floors were dirty, bent and rusted. The entire flooring and perimeters of room were unkempt and upswept, giving the appearance the floors were not cleaned. The physical therapy blue foam mat on the treatment table with two Roho cushions (cushions to prevent pressure sores), a foam wedge and foam pillow were observed dirty and worn out. During review of the rehabilitation room a strong smell of urine was noted around the SCIFIT machine and in the front area of the floor with the three floor vents. Physical Therapy Assistant (PTA) K recognized the strong urine odor and recognized was more noticeable when the heat is on. RM J concurred. On 12/3/25 at 10:50 AM, Environmental Services Manager (ESM) I confirmed that housekeeping is responsible for daily dusting, cleaning the floors in the common areas and rehabilitation room. When shown the floor heat vents throughout the areas observed, ESM I acknowledged they were not clean, rusted, and should not contain the dust, grime, and dead insects. The floor inspected in the social room and rehabilitation was also acknowledged they were unkempt. ESM I also concurred the within the hallway starting at room [ROOM NUMBER] up to the rehabilitation room and within the rehabilitation room had a strong odor of urine. On 12/4/25 at 10:30 AM- the odor of urine in the hallway started at room [ROOM NUMBER] up to the rehabilitation room and within the rehabilitation room was intensified then the day before. Upon (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entrance into the rehabilitation room it was observed the sun was coming into the windows provided a warmer temperature amongst the room. RM J remarked housekeeping had cleaned the floors and was uncertain why the urine smell still permeated within the room. On 12/4/25 at 11:30 AM, Certified Nurse Assistant (CNA) N was asked to permit entry into the east shower room. CNA N confirmed there was one shower bed in the facility and a few of the residents require it. A blue colored shower bed mattress was observed with various sized rips and tears exposing the interior tan colored foam like material. On 12/4/25 at 11:45 AM, room [ROOM NUMBER] was observed with an Enteral Nutrition (tube feed) pole, pump, and hanging tan colored tube feed nutrition. The electronic feeding pump was observed with dried spilled tube feed matter on the face and sides of the pump. The pole and stand were also observed with moderate amounts of tan colored dried stained tube feed. On 12/4/25 at 11:50 AM, room [ROOM NUMBER] was observed with a tube feed pole, pump, and hanging tan colored tube feed nutrition. The electronic feeding pump was observed with dried spilled tube feed matter on the face and sides of the pump. The pole and stand were also observed with moderate amounts of tan colored dried stained tube feed. Splashes of the same dried tan colored matter were also observed splashed onto a black portable oxygen concentrator and on the floor around the equipment. Observations throughout the survey from 12/2/25 – 12/4/25 revealed multiple instances of lingering urine odors and stagnant air throughout room [ROOM NUMBER] and 119, the center hallway and therapy gym. On 12/4/25 at 11:20 AM, R42 was observed laying in bed. Upon entering the room, there was an extremely strong urine odor. The overbed light pull cord chain was only about a foot in length and the resident was not able to reach to utilize. The three-drawer bedside dresser was observed to have two of the three drawer handle pulls missing. On 12/4/25 at 11:25 AM, an observation of the west and center hall was conducted with the Environmental Services Manager (Staff 'I'). Upon entering room [ROOM NUMBER], it was observed that the built-in dresser was missing the top drawer hardware drawer pulls. Upon entering room [ROOM NUMBER], Staff 'I' confirmed the missing drawer pulls. When asked about the missing drawer pulls for the dressers, Staff 'I' reported they had not noticed those and would look for replacements. On 12/4/25 at 12:12 PM, the Administrator was requested to provide a policy for overbed light pull cords. At 2:06 PM, the Administrator reported there was no specific policy.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure the call light was accessible to the resident for one (R32) of three residents reviewed for accommodation of needs. Findings include:On 12/2/25 at 1:48 PM, R42 was observed lying in bed. The call light was observed laying on the floor mat out of reach of the resident. When asked if they needed to summons assistance, how would they do that, R42 reported they would Yell for help. They further reported they could not reach the call light from where it was currently placed on the floor.At 1:50 PM, the assigned Certified Nursing Assistant (CNA ?D') entered the room and when asked about the placement of the call light on the floor, CNA ?D' reported He pushed that off.On 12/4/25 at 11:20 AM, R42 was observed lying in bed. The call light was observed placed around the bedside dresser approximately four feet away from the resident while in bed. The resident was asked if they could reach the call light if they needed to ask for assistance and they stated they could not.On 12/4/25 at 11:35 AM, during an observation of R42's room with Nurse Manager (NM ?H?), they confirmed the placement of the call light and reported that should be kept within reach and proceeded to place next to the resident on the bed. At that time, R42's assigned CNA ?G' entered the room and when asked about the call light being placed out of reach, around the bedside dresser, CNA ?G' reported they had placed the call light on the bedside dresser when they were pulling the resident up in bed for breakfast earlier and acknowledged it had been out of reach since then.On 12/4/25 at 12:12 PM, the Administrator was requested to provide a policy for call light placement.According to the policy titled, Call Lights Accessibility & Timely Response Policy dated 3/2025: .With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secure, as needed.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure chemical restraints were not utilized for staff convenience, and without identification of non-pharmacological approaches attempted for one (R42) of one resident reviewed for psych/opioid medication side effects. Findings include:On 12/02/2025 at 10:45 AM, R42 was observed lying in bed, asleep. They did not awaken upon verbal stimuli.Review of the clinical record revealed R42 was admitted into the facility on 1/12/24 and readmitted on [DATE] with diagnoses that included: cognitive communication deficit, adult failure to thrive, other psychotic disorder not due to a substance or known physiological condition, delusional disorders, Alzheimer's disease with early onset, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, insomnia, and malignant neoplasm of bladder.According to the Minimum Data Set (MDS) assessment dated [DATE], R42 had no communication concerns, had moderately impaired cognition, had no signs/symptoms of delirium, delusions, or hallucinations, had no mood or behavioral concerns, and received antianxiety medication.Review of R42's medications included two orders for Lorazepam (Ativan) an antianxiety medication.One order was for scheduled Lorazepam 1 MG (Milligram) give one tablet by mouth at bedtime for anxiety or restless (to be given at 9:00 PM) was started on 11/23/25.Another order for Lorazepam 0.5 MG give one tablet by mouth every six hours as needed (PRN) for anxiety and restlessness for 12 days was started on 11/25/25.According to the Medication Administration Records (MARs) and corresponding controlled substance records, R42 received their scheduled Lorazepam and two doses of the as needed Lorazepam on 11/26/25 at 8:00 AM and on 12/1/25 at 7:51 AM. Both MAR entries were documented as administered by Nurse ?C'. The section of the MAR to enter notes for the 12/1/25 7:51 AM administration was left blank.Further review of the documentation available in the clinical record revealed there was no identification of distressing behaviors or any non-pharmacological approaches attempted prior to giving these two as needed Lorazepam administrations.Review of the available documentation included:An entry on 12/1/25 at 8:51 AM by Nurse ?C' read:Resident was attempting to get out of bed talking about going back to work They are waiting for him outside there. PRN anxiety med given with good effect. Currently eating food from lunch tray. Calm down now.A late entry on 12/1/25 at 12:24 PM for 11/26/25 at 9:08 AM by Nurse ?C' read: Resident was talking to self, looking up straight to air like yes you are right am still working here I will see you soon when you come. I am getting out of bed now to see you ok. PRN Ativan given earlier with good effect. MD aware. Safety maintained. On 12/3/25 at 2:07 PM, Nurse ?C' was attempted to be contacted by phone and a message was left to return the call.On 12/3/25 at 3:35 PM, an interview was conducted with the Director of Nursing (DON). When asked to explain the facility's process for administering as needed psychotropic medication, the DON reported the nurses should try other non-pharmacological interventions first. When asked where that would be documented, the DON reported in the progress notes or on the MAR. The DON further reported they had previously had discussions with Nurse ?C' about this same concern. The DON reviewed the documentation by Nurse ?C' for both administrations, and they reported the documentation as written did not capture what actually happened. The DON reported R42 gets extremely restless and agitated but acknowledged the documentation as written did not reflect that, nor did it include the non-pharmacological approaches attempted prior to administration.According to the facility's policy titled, Psychotropic Medication Policy dated 3/1/2025: . Chemical restraint refers to any drug used for discipline or that makes it more convenient (i.e., less effort) for staff to care for a resident, and not required to treat medical symptoms. This includes instances when a psychotropic medication may be approved to treat certain symptoms, however, nonpharmacological interventions should be used or attempted, unless clinically contraindicated, because they are less dangerous to a resident's health (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and safety.Non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure pain medication was administered per physician's orders and documentation in the record was accurate in accordance with nursing professional standards for one resident (R31), of one resident reviewed for nursing professional standards. Findings include: On 12/2/25 at 10:02 AM, R31 was observed in their wheelchair in the doorway of their room leading out to the hallway. They were observed to be moaning and complaining of pain in their neck. On 12/2/25 at 10:11 AM, Registered Nurse (RN) 'A' was observed to assess R31. R31 requested RN 'A' to call their physician due to their pain. On 12/2/25 at 10:14 AM, RN 'A' was overheard talking to R31 and telling them they phoned the physician, and the physician ordered oxycodone (narcotic pain reliever) for pain. A review of a progress note entered into the record by RN 'A' on 12/2/25 at 10:22 AM, was reviewed and read, .Resident reported pain on his back of neck, NP (Nurse Practitioner) .notified, ordered Oxycodone 5mg (milligram) PRN (as needed) for 5 days. Order noted and carried out .On 12/2/25 at 11:21 AM, a review of R31's physician's orders was reviewed and revealed an order dated 12/2/25 for oxycodone 5 mg every twelve hours as needed. R31's medication administration record (MAR) was also reviewed, however; the MAR did not document any administration of the oxycodone medication.On 12/3/25 at 8:55 AM, R31 was observed in the hallway seated in their wheelchair in the doorway of their room. They were asked how their neck felt and said, It still hurts.On 12/3/25 at 9:56 AM, a second review of R31's MAR was conducted and revealed no documented administrations of oxycodone on 12/2/25, the day R31 complained of the pain and the day the medication had been ordered. On 12/3/25 at 10:02 AM, a review of a controlled substance log sheet for R31's oxycodone was reviewed and did not document any removals of the medication from their supply on 12/2/25. At that time, an interview was conducted with RN 'A'. RN 'A' said they removed 5 mg of oxycodone from the facility's back-up medication supply and administered it on 12/2/25. They were asked why it was not documented on the MAR and reported the MAR would not allow them to document an administration because the physician had not signed the order for the controlled substance. RN 'A' was then asked to provide any type of proof the medication had been pulled from the back-up medication supply. RN 'A' left the unit and returned approximately 10 minutes later without evidence the medication had been pulled from the back-up medication supply on 12/2/25. It is noted there was no evidence R31 received the oxycodone on 12/2/25 despite RN 'A's note on 12/2/25 at 10:22 AM that documented they, carried out the physician's order. RN 'A' was asked again if they administered the oxycodone pain medication on 12/2/25 and gave no confirmation or denial of administering the medication. They further went on to say R31 had received Tylenol earlier in the morning on 12/2/25 and if R31 had received the oxycodone medication, they still would complain of pain. On 12/3/25 at 10:32 AM, an interview was conducted with the facility's Director of Nursing (DON). They were asked if a medication pulled from the back-up medication supply could be documented on the MAR without the physician's signature on the order and they said it could. The DON was then made aware of the incident on 12/2/25 when RN 'A' said they pulled 5 mg of oxycodone for R31 but did not sign it out on the MAR and could provide no evidence it had been pulled from the back-up supply despite their note indicating they gave the medication. The DON said the medication should have been given and documented on the MAR. They were further informed of Nurse 'A's comment regarding R31 still complaining of pain whether they had received the oxycodone or not and said, The resident's pain is what the resident says it is and they should have gotten the medication. A review of a facility provided document for the expectations of a Registered Nurse was reviewed and read, .The Registered Nurse is responsible for performing a variety of duties to provide quality nursing care .Accurately record resident observations .Administer medications to residents according to the Public Health Code, Nursing Department Policies, and standards and procedures as prescribed by the physician .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pain medications were administered as ordered for one resident (R31), of one resident reviewed for pain, resulting in repeated complaints of pain and discomfort. Findings include: On 12/2/25 at 10:02 AM, R31 was observed in their wheelchair in the doorway of their room leading out to the hallway. They were observed to be moaning and complaining of pain in their neck. Nurse 'B' was at the medication cart in the hallway adjacent to R31 and was overheard to tell R31 they just received Tylenol and asked them if they could give the Tylenol time to work. R31 replied by saying the Tylenol has not been working and their neck hurt, real bad describing the pain as moving down the middle of their neck. At that time, R31 told Nurse 'B' they wanted to go to the hospital. Nurse 'B' again asked R31 if they could give the Tylenol more time to, kick in. On 12/2/25 at 10:11 AM, Nurse 'A' was observed to assess R31 and asked R31 to give the Tylenol administered by Nurse 'B' another hour to begin working. R31 protested to Nurse 'A' and requested Nurse 'A' call their physician.On 12/2/25 at 10:14 AM, Nurse 'A' was overheard talking to R31 and telling them they phoned the physician, and the physician ordered oxycodone (narcotic pain reliever) for pain. A review of a progress note entered into the record by Nurse 'A' on 12/2/25 at 10:22 AM, was reviewed and read, .Resident reported pain on his back of neck, NP (Nurse Practitioner) .notified, ordered Oxycodone 5mg (milligram) PRN (as needed) for 5 days. Order noted and carried out .On 12/2/25 at 11:21 AM, a review of R31's physician's orders was reviewed and revealed an order dated 12/2/25 for oxycodone 5 mg every twelve hours as needed. R31's medication administration record (MAR) was also reviewed, however; the MAR did not document any administration of the oxycodone medication.On 12/3/25 at 8:55 AM, R31 was observed in the hallway seated in their wheelchair in the doorway of their room. They were asked how their neck felt and said, It still hurts.On 12/3/25 at 9:56 AM, a second review of R31's MAR was conducted and revealed no documented administrations of oxycodone on 12/2/25, the day R31 complained of the pain and the day the medication had been ordered. On 12/3/25 at 10:02 AM, a review of a controlled substance log sheet for R31's oxycodone was reviewed and did not document any removals of the medication from their supply on 12/2/25. At that time, an interview was conducted with Nurse 'A'. Nurse 'A' said they removed 5 mg of oxycodone from the facility's back-up medication supply and administered it on 12/2/25. They were asked why it was not documented on the MAR and reported the MAR would not allow them to document an administration because the physician had not signed the order for the controlled substance. Nurse 'A' was then asked to provide any type of proof the medication had been pulled from the back-up medication supply. Nurse 'A' left the unit and returned approximately 10 minutes later without any evidence the medication had been pulled from the back-up medication supply on 12/2/25. They were asked again if they administered the medication on 12/2/25 and gave no confirmation or denial of administering the medication.A review of R31's clinical record was conducted and revealed they admitted to the facility on [DATE] with diagnoses that included: spinal stenosis, heart attack, diabetes, bipolar disorder, epilepsy, osteoarthritis, delusional disorder, schizoaffective disorder, and dementia. R31's most recent Minimal Data Set (MDS) assessment dated [DATE] indicated R31 had moderately impaired cognition. A review of R31's care plans was conducted and read, .Care Plan Focus I may experience pain 2/2; Spinal Stenosis .Interventions/Tasks .Anticipate my need for pain relief and respond immediately to any complaint of pain .On 12/3/25 at 10:32 AM, an interview was conducted with the facility's Director of Nursing. They were asked if a medication pulled from the back-up medication supply could be documented on the MAR without the physician's signature on the order and they indicated it could. They were made aware of the incident on 12/2/25 when Nurse 'A' said they pulled 5 mg of oxycodone for R31 but did not sign it out on the MAR and could provide no evidence it had been pulled from the back-up supply, and they said the medication should have been given and documented in the record. A review of a (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility provided document titled, Pain Management revised 7/2025 was conducted and read, .The facility must ensure pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences .

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain mechanical ventilation, resulting in lingering odors and uncirculated air, affecting four residents that share a bathroom in room [ROOM NUMBER] and 119, and throughout the center hallway and therapy gym. Findings include:Observations throughout the survey from 12/2/25 - 12/4/25 revealed multiple instances of lingering urine odors and stagnant air throughout room [ROOM NUMBER] and 119, the center hallway and therapy gym.On 12/2/25 at 10:45 AM, room [ROOM NUMBER] and 119 were observed to have an extremely strong urine odor which was acknowledged by the residents. The shared bathroom exhaust vent of resident room [ROOM NUMBER] and 119 was tested using a piece of toilet paper to test the exhaust function and no suction was observed.On 12/4/25 at 11:25 AM, on observation of the west and center hall was conducted with the Environmental Services Manager (Staff ?I'). When asked about lingering urine odor and stagnant air on the center hall, Staff ?I' acknowledged the same odors and deferred to nursing for room [ROOM NUMBER].On 12/4/25 at 11:35 AM, Nurse Manager (NM ?H') who also functioned as the facility's Infection Preventionist was asked to observe the resident in room [ROOM NUMBER]. Upon entering the resident's room, NM ?H' confirmed the strong urine odor and reported that maybe the resident had messed with their urostomy (a surgical opening on the abdomen to redirect urine from the urinary tract to an external collection pouch) and it leaked. Within a few minutes, the resident's assigned Certified Nursing Assistant (CNA ?G') entered the room and when asked about the urine odor, CNA ?G' checked the resident's urostomy area and reported it was dry.On 12/4/25 at 11:45 AM, Staff ?I' was requested to evaluate the facility's bathroom ventilation and they reported that was done on their rounds routinely. When asked how they checked to make sure the system was functioning properly, Staff ?I' reported they checked if the blades were moving. At that time, they were requested to hold a piece of toilet paper to the ventilation grid and upon doing so, the toilet paper did not suction to the grid, despite the sound of a fan motor. Continued observations of other rooms throughout the center hallway revealed they were functional (toilet paper suctioned to exhaust vent).On 12/4/25 at 12:12 PM, the Administrator was requested to provide a policy for ceiling/bathroom ventilation. At 2:06 PM, the Administrator reported there was no specific policy.