STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235666	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Grand Blanc	1330 Grand Pointe CT Grand Blanc, MI 48439

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignity by not having the call lights accessible, extended call light response times, and not treating residents in a respectful manner for five residents (Res. #15, Res. #50, Res.#187, Res. #289, & Res.#391) of five residents reviewed for dignity and respect and call light response times, resulting in fear of abandonment, isolation and decreased socialization and the potential for falls or accidents. Findings include: Resident #15 (R15) Dignity During the initial tour on 06/10/25 at 1:11 PM, Resident #15 was observed eating popcorn in bed in his room. During the initial interview, R15 revealed that he could not see any more since he was diagnosed with Glaucoma; he is now blind. When asked if he had access to his call light, he said he would often feel around his bed to find it but could not find the call light button. During an observation on 6/10/25 at 1:12 PM, Nurse M, assigned to R15, found the call light on the floor underneath his bed. Nurse M crawled under R15's bed and picked up the call button. She then clipped the call light cord on the bed and ensured R15 held the call button in his hand. The surveyor reviewed R15's Electronic Medical Records (EMR) on 6/11/25 at 11:00 AM. It revealed that R15 was admitted to the facility on [DATE]. He was admitted with a diagnosis of Senile Degeneration of the brain, Osteoporosis, History of Falling, and Blindness (both eyes) in addition to other diagnoses. His Brief Interview of Mental Status dated 4/10/2025 revealed a BIMS score of 07/15. A BIMS Score of 07 means moderately impaired cognitive status. His care plan for safety includes putting the call light within reach and encouraging him to use the call light for assistance as needed. Nurse M was interviewed on 6/10/25 at 1:15 PM. Nurse M admitted that the staff did not make the call light accessible. Nurse M stated that R15 was blind and picked up the call light from underneath the bed and acknowledged that the call light was not in a place where it was reachable. Resident #187 Dignity (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed R187's Electronic Medical Record (EMR) on 6/11/25 at 3:30 PM. R187 was [AGE] years old and admitted to the facility on [DATE] with the diagnosis of Acute Chronic Diastolic Congestive Heart Failure, Metabolic Encephalopathy, Morbid Obesity, and Type 2 Diabetes Mellitus, in addition to other diagnoses. The Minimum Data Set (MDS) with an assessment date of 6/3/25, R187's Brief Interview of Mental Status (BIMS) Score was 15/15. A score of 15 means that the resident was cognitively intact. A review of R187's Plan of Care revealed that the facility initiated a safety care plan on 5/31/25. It specifically indicated that 1.) anticipate and meet needs PRN (as needed). 2.) Another was encouraging the resident to use a bell/call light for assistance . 7.) Put the call light within reach and encourage her to use it for assistance as needed. R187's care plan for toileting initiated on 5/30/25 indicated the following: .2.) Check the Resident frequently and PM for incontinence. Wash, rinse, and dry the perineum. Change clothing PRN after incontinence episodes .3.) TOILET HYGIENE: Resident (R187) requires substantial/Maximal assist, with one helper. Assist with the bathroom frequently to avoid incontinence accidents. 4.) TOILET TRANSFER: Resident requires partial/moderate assistance with one helper . During the interview with R178 on (DATE/TIME, R187 reported leaving her alone in the hallway after lunch for a prolonged period. No one had brought her back to her room after lunch, and she stayed in the hallway for at least a couple of hours. No one took her to the bathroom, and she did not have the call light in the hallway. R187 stated, I had an accident and was soaked in urine for a long time. R187's son was interviewed on 6/10/25 at 4:04 PM. R187's son identified himself as the primary caregiver of R187 at home when discharged . He stated he had found R187's call light button on the floor at least twice, and when she needed assistance, it took a long time for them to respond to the call light. He described the response time as being from an hour to two hours. R187's son had indicated that R187 takes a water pill (Lasix) daily and that his mother has anxiety, especially with accidents if toileting assistance is delayed. R187's son stated, My mom feels embarrassed when she can't reach the bathroom in time.

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide advanced written notification of a room change and obtain consent for one resident (Resident #70) of one resident reviewed, resulting in a cognitively intact resident not being informed of and/or provided the rationale for a room change prior to their room being moved. Findings include: Resident #70: On 6/10/25 at 1:13 PM, an interview was completed with Resident # 70 in their room. When queried if they had been in this room since they were admitted to the facility, Resident #70 verbalized they were in a different room before. Resident #70 was queried regarding the room change and stated, I just came back, and all my stuff was gone. I was mad. When queried if they were notified of the room change and the reason for the change prior to their personal items being moved to a different room, Resident #70 stated, No. When asked where they were when their personal items were relocated, Resident #70 revealed they thought they were in therapy. Resident #70 then stated, I asked the CNA's (Certified Nursing Assistants) and they didn't know why they were moved rooms. Record review revealed Resident #70 was admitted to the facility on [DATE] with diagnoses which included bipolar disorder, depression, anxiety, and colostomy (surgically created opening in the abdomen allowing for the passage of stool into an external bag). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to substantial assistance to complete Activities of Daily Living (ADL) with the exception of set-up assistance for eating and oral hygiene. Review of Resident #70's Electronic Medical Record (EMR) revealed the Resident made their own medical and financial decisions. Review of Resident #70's EMR census documentation revealed the Resident was moved rooms on 3/12/25. Review of documentation in Resident #70's EMR revealed a Notice of Room Change assessment form dated 3/12/25. The assessment specified, 4. A copy of this notice has been reviewed with the resident/guest or responsible party and will be provided upon request . Yes . Name of person to whom this notice was reviewed with and provided to if requested: Left message for Son . The form was signed by Social Services Staff I on 3/14/25. An interview was conducted with CNA H on 6/11/25 at 3:46 PM. When queried if they were working when Resident #70 was moved room, CNA H replied, Yes. When asked if the Resident was upset about the move, CNA H responded, Yes. When it first happened, (Resident #70) was confused and didn't understand why it was happening. CNA H stated, (Resident #70) said no one told them (about moving rooms) or explained it. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 4:04 PM, an interview was completed with Social Services Staff I. When queried if Resident #70 is their own person and makes their own medical decisions, Staff I replied, Yeah. Resident #70's Notice of Room Change assessment was reviewed with Staff I at this time. When asked why the son was the only person listed as being contacted regarding the change on the assessment form, Staff I stated, I always contact whoever they list their next of kin so they know where they are when they come to visit. When queried why Resident #70 was not notified prior to the room change, Staff I stated, I am still kind of learning. Staff I was informed of Resident #70's verbalization of emotional distress related to not being made aware of the move and indicated they were unaware the Resident had been upset. When queried, Staff I confirmed understanding of the concern. An interview was completed with the Acting Director of Nursing (DON) on 06/12/25 at 9:12 AM. When queried if residents should be notified prior to room changes and if they have the right to refuse to move rooms, the DON responded that residents should be notified. The DON was informed of Resident #70's verbalization of emotional distress related to not being informed of moving rooms but did not provide further explanation. A policy/procedure related to notification of room change was requested from the facility Administrator on 6/11/25 at 4:39 PM but not received by the conclusion of the survey.

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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, interview and record review, the facility failed to ensure five residents' (#1,#7, #13, #37 and #42) wheelchairs/Amigos were regularly cleaned, sanitized and free from damaged areas of six reviewed for a homelike environment. Findings Include: During Resident Council held on 6/11/2025 at 10:20 AM, five residents' wheelchairs or amigos were observed to have packed substances in the crevices, worn cushions, and varying areas of dried on substances. When asked if their wheelchairs were cleaned on a regular basis, they stated they were not. None could recall when the last time their wheelchair had been cleaned. Review was completed of Resident #1, #7, #13, #37 and #42's wheelchair cleaning task log for the last 30 days. The documentation indicated their wheelchairs were being cleaned weekly, but observations made indicated they were not being consistently cleaned. The following was documented: Resident #1: Wheelchair was last cleaned on 6/5/2025. Resident #7: Wheelchair was last cleaned on 6/3/2025. Resident #13: Wheelchair was last cleaned on 6/5/2025. Resident #37: Wheelchair was last cleaned on 6/5/2025. Resident #42: Wheelchair was last cleaned on 6/5/2025. On 6/11/2025 at 4:10 PM, Environmental Services Director E reported his staff typically inspect and clean resident wheelchairs monthly. Residents' wheelchairs were observed with Director E. Resident #1 Was in the dining room and she reported it was unknown the last time her motorized wheelchair was cleaned. Dust/debris were visible in various areas on her chair. Resident #37 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident was in her room and the back seat cushion had four 3-4-inch ripped areas and multiple areas of dust/debris build up in crevices. The wheelchair was visibly soiled in multiple area and she reported she does not recall the last time it was cleaned. Resident #42 Resident was visiting with family/friends in the dining room and her wheelchair had crusted on substances, dust and other debris. The resident reported staff do not clean their wheelchairs. Resident #13 Resident was in the common area playing solitaire on the computer. The crevices of the foot rest had varying debris and dust particles. Resident #1 stated she does not recall the last time her [NAME] was cleaned. Resident #7 Resident was in the dining room and her [NAME] had thick buildup of substances in between the wheels and handles. Director E stated he understood the concern, as the wheelchairs were observed to be visibly soiled in multiple areas and it did not appear regular cleaning was being addressed.

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F 0689 Level of Harm - Minimal harm or potential for 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** Resident #18 (R18): Accidents On 06/12/25 at 12:34 PM, a review of R18's Electronic Medical Record (EMR) was conducted. R18 was [AGE] years old, admitted to the facility on [DATE] under hospice care with the diagnosis of Congestive heart failure, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Vascular Dementia, Difficulty in Walking, weakness, and End Stage Renal Disease ESRD)in addition to other diagnoses. R18's Minimum Data Set (MDS) assessment, dated March 15, 2025, revealed a Brief Interview for Mental Status score of 07/15. A score of 0-7 indicates that the individual has severe cognitive impairment. The R18's plan of care, dated 2/12/25, did not include ensuring safety and monitoring body placement in a chair or bed after the Resident's dialysis or when up on a chair unsupervised. R18 goes to dialysis treatment three (3) times a week and has a functional ability deficit requiring assistance with self-care and mobility. R18 required substantial/maximum assistance with a 2-person assist for bed mobility and transfers. R18's care plan revealed that he has visual function impairment due to open-angled glaucoma of the right eye. R18 was care planned to use the call light for assistance; the call light must be within reach, and the patient must maintain an appropriate bed positioning. According to the fall incident report (IR) dated 6/11/2025 at 18:25 (6:25 PM), it revealed: During rounds, a nurse found a guest lying on the floor in front of a wheelchair with the left side of the head on the bottom railing of the bedside table. The Resident is unable to give a description. Immediate Action: The guest (R18) was assessed for injury. A small abrasion above the left eyebrow with swelling around the eye was noted. Vitals obtained . The IR under Predisposing Environmental Factors indicated that the Wheelchair brakes were found unlocked. The IR also revealed that R18's Predisposing Physiological Factors specified that R18 was confused. The incident report did not specify if the Resident activated the call light or if the call light was within reach. There was no indication of when R18 was last toileted, nor of R18's whereabouts or activities from the time he arrived from dialysis to the time he was observed on the floor. On 6/12/25 at 12:30 PM, R18's Electronic Medical Record was reviewed. According to the Nurse's Notes on 6/11/2025 at 19:26 (7:26 PM), the nurse wrote: During rounds, a nurse found guest (R18) lying on the floor in front of a wheelchair with the left side of the head on the bottom railing of the bedside table. Guest (R18) was unable to describe what he was trying to do before the fall. Guest(R18) was assessed for injury. A small abrasion above the left eyebrow was found. Vitals obtained. Guest assisted bed with Hoyer lift . R18 was observed in his room, lying in bed on 6/12/25 at 12:43 PM. During an interview, R18 described that he fell recently and tried to explain how he sustained a small cut on his left eyebrow. He had indicated that he had fallen but was having difficulty explaining how it had happened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Nurse M was conducted on 6/12/25 at 1:10 PM. She revealed that R18 fell yesterday (on 6/11/25 at around 7 PM after her shift. The nurse further described that R18 came back from dialysis after 4:00 PM and fell out of his wheelchair after dinner. Nurse M stated, he must have been tired, as he had just returned from dialysis. But there were no witnesses, so we don't know what had actually happened. During an interview with the Unit Manager Nurse E on 06/13/25 at 10:01 AM, R18 returned from dialysis after 4:00 PM on 6/11/25 and was later found on the floor in his room. He sustained an abrasion on his eyebrow, but since the fall was unwitnessed, we were not sure what had happened. R18 was unable to describe the incident. The Unit Manager was unable to identify the nursing assistant during the fall because the incident report did not specify the names of staff involved at the time of the incident, and there were no statements from the aide assigned at the time. Unit Manager E commented, I don't know why CNA did not put him in bed right after he arrived from dialysis. Residents often become extremely tired after returning from dialysis. Staff needed to check on him. The Unit Manager, E, after reviewing the logs, indicated that R18 arrived from dialysis at 5:10 PM on June 11, 2025, and fell an hour later at 6:25 PM. According to Unit Manager E, a post-fall statement by the nurse aide revealed that R18 was dry after the fall. There was no description of any fall interventions implemented to prevent falls after coming back from dialysis. Based on observation, interview and record review, the facility failed to ensure the provision of adequate supervision and implementation of meaningful interventions to prevent falls for two residents (#14, #18) of four residents reviewed, resulting in Resident #14 experiencing a fall with a hip fracture. Findings include: Resident #14: On 6/10/25 at 12:54 PM, Resident #14 was observed sitting near the nurse's station in their wheelchair. An overbed table with a meal tray was positioned in front of the Resident and they were eating. The Resident's right leg was positioned on the wheelchair leg rest and their left leg was off the wheelchair leg rest with their left foot on the base of the overbed table. The Resident began moving their left leg and appeared restless. When spoke to, Resident #14 was pleasantly confused and unable to provide meaningful responses to questions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Licensed Practical Nurse (LPN) J on 6/10/25 at 12:59 PM. When queried why Resident #14 was eating alone in the central area near the nurses' station, LPN J stated, (Resident #14) self-transferred a couple weeks ago and broke their hip. That's why they're out here. When asked if they needed to be supervised when they ate, LPN J responded, (Resident #14) still tries to self-transfer. (Resident #14) is confused. LPN J was asked if Resident #14 attempted to self-transfer before they fell and fractured their hip and replied, Yeah. When queried if the Resident attempted to get up without assistance frequently prior to the fall with fracture, LPN J stated, They did. LPN J revealed Resident #14 would try to get up by themselves all the time. With further inquiry, LPN J revealed the intervention to keep the Resident in the area by the nurses' station was implemented following the fall with hip fracture. When queried regarding the Resident moving their left leg and appearing either restless, LPN J indicated the Resident frequently moved around and was still attempting to self-transfer. Record review revealed Resident #14 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included heart disease, history of falls, and displaced intertrochanteric fracture of the right femur (specific type of hip fracture involving the top of the femur bone). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required substantial/maximum assistance with rolling from side to side, sitting up, and standing. The MDS further detailed the Resident had a history of falls. Review of Resident #14's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #14) is at risk for fall related injury and falls R/T (related to): weakness, decreased mobility, hx (history) of falls, medication side effects, new environment, attempts at self transfer (Created and Initiated: 5/8/25; Revised: 6/4/25). The care plan included the interventions: - Encourage resident to wear non-skid foot wear when out of bed. Assist resident as needed (Initiated: 5/9/25) - Keep the resident's environment as safe as possible with: even floors free from spills and/or clutter; adequate lighting; call light within reach, commonly used items within reach, avoid repositioning furniture and keep the bed in the appropriate position (Initiated: 5/8/25) - Offer toileting when rounding during nighttime hours (Initiated: 5/15/25) - Provide resident with activities that minimize the potential for falls while providing diversion and distraction (Initiated: 5/8/25) - Put the call light within reach and encourage . to use it for assistance as needed (Initiated: 5/8/25; Revised: 6/4/25) - Red tape around call light (Initiated: 5/22/25) - Staff to assist (Resident) to stay covered with a blanket while in recliner (Initiated: 5/28/25) - Staff to assist to bathroom frequently (Initiated: 5/23/25) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RESOLVED: Keep residents w/c (wheelchair) next to bed in the middle of the night in case attempts to get up . could use the wheelchair for assist (Initiated: 5/15/25; Revised and Resolved: 5/15/25) Another care plan entitled, (Resident #14) has a functional ability deficit and requires assistance with self-care/mobility R/T (related to): weakness, decreased mobility (Created: 5/8/25; Initiated: 6/4/25) included the intervention, Transfer: Resident is substantial/maximum with 2 helpers for transfers (Created: 5/8/25; Initiated: 6/9/25). Review of Resident #14's Census information in the EMR revealed the Resident was discharged from the facility on 5/29/25 and returned on 6/4/25. A review of progress note documentation in Resident #14's EMR revealed the following: - 5/15/25 at 4:00 AM: Nurses Notes . resident was heard yelling help from (their) room. Upon entering resident was observed laying on the floor on back parallel to the dresser at the foot of bed. Resident c/o right knee pain . - 5/15/25: Health Care Provider Encounter . Telehealth - Asynchronous . Situation: Nurse reports pt was just observed on the floor in room . was trying to walk to the bathroom and doesn't walk, fall protocol initiate . 5/22/25 at 10:30 PM: Nurses Notes . resident observed on floor next to bed in room . assessed for injury, none at this time. resident assisted into wheelchair x2 staff . assisted into recliner in common area for monitoring . - 5/28/25 at 7:14 AM: Nurses Notes . Patient was observed on the floor by recliner that sits by nursing station. Patient was previously observed lying in (their) recliner and later toileted at 0435. After patient was then placed back into recliner and shortly morning medications were passed at 0509. At 0520 patient was then observed on the floor lying on back with legs flexed toward body . arms were by side and head lying on floor. Patient was then observed for any immediate injuries ROM (Range of Motion) was attempted. Patient did complain of pain in right hip. Patient was then placed into wheelchair and further assessed for injuries which none were noted at this time . - 5/29/25: Health Care Provider Progress Notes . Acute . seen for follow up on x-ray. Patient had fall from recliner, Xray was ordered and states acute right femoral neck fracture . patient to be sent to ER to address acute issue . Review of Resident #14's x-ray report dated as reported on 5/29/25 at 1:29 AM revealed, Findings: There is an acute right femoral neck fracture with mild displacement (bone broken and not aligned) . Conclusion: Acute right femoral neck fracture. Review of Resident #14's Hospital Medical Records revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/29/25 at 12:47 PM: History and Physical . presented to ER with complaint of a fall at (Facility) with a possible hip fracture . patient is poor historian so most information is taken from (family member) at the bedside . (Family member) stated that (Resident #14) was up in a wheelchair at the nurse station at about 5:30 yesterday morning and tried to get up and became twisted in the blanket and fell . Review of Symptoms . Neuro: Positive: confusion/memory loss, falls, weakness . Musculoskeletal: Positive: joint swelling, pain, stiffness . Physical Examination . Acutely ill appearing . Diagnostic Result . XR (Xray) Femur right . Femoral neck irregularity likely nondisplaced fracture . XR Right Hip . Slightly impacted right femoral neck fracture . - 5/30/25: Operative Summary Report . Right closed displaced femoral head fracture . Procedure performed: 1. Right hip hemiarthroplasty (placement of prosthetic femoral head which is the ball section of the hip joint) . Application of incisional VAC (Vacuum Assisted closure) right hip (device which uses negative pressure to assist in wound healing) . On 6/11/25 at 8:00 AM, Resident #14 was observed sitting in their wheelchair near the nurses' station alone. The Resident did not have any activities to occupy themselves and did not have a call light and/or other method to contact staff. On 6/11/25 at 2:39 PM, Resident #14 was observed sitting in a recliner near the nurses' station. The Resident did not have any activities in place and did not have a call light and/or other method to contact staff. An observation of the nurses' station revealed the Resident was not able to be visualized when sitting due to the height of the nurses' station counter. On 6/11/25 at 4:39 PM, Resident #14's Incident and Accident forms, as well as any associated investigation documentation was requested from the facility Administrator via email. The requested I and A forms for Resident #14 were received on 6/12/25 at 9:00 AM but no additional associated investigation documentation was provided. On 6/12/25 at 9:40 AM, Resident #14 was observed sitting in their wheelchair near the nurses' station. The resident was fidgeting in their chair. The Resident did not have anything to do and/or to occupy them. No staff were present at the nurses' station or within view of where Resident #14 was positioned in their wheelchair and Resident #14 did not have a call light and/or any other method to contact staff. The first staff to approach the nurses' station was Activity Staff K at 9:48 AM. Staff K approached Resident #14 and asked them if they would like to go to an activity. Resident #14 told Staff K they were unable to hear them. Staff K repeated themselves at the same tone and volume and Resident #14 repeatedly told Staff K they could not understand what they were saying. At 9:50 AM, Staff K then walked away from the Resident and left the Resident alone with nothing to do and/or no entertainment and no call light. There were no staff present at the nurses' station and/or near the Resident. At 12:42 PM on 6/12/25, Resident #14 was observed sitting alone in the same place in their wheelchair by the nurses' station alone. The Resident did not have anything in place to do and/or activities in place. They did not have a call light and/or any other method to contact staff if needed. Review of facility provided I and A forms revealed Resident #14 had three falls in May 2025. The I and A forms detailed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Grand Blanc	1330 Grand Pointe CT Grand Blanc, MI 48439

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/15/25 at 3:15 AM: Fall . Resident Room . Resident was observed laying on back parallel to the dresser at the out of bed .was hollering help and discovered there Resident Description: I was trying to go to the bathroom . Immediate Action Taken . Resident was lifted to a standing position and eased into the bed with assist . c/o (complain of) right knee pain of which had c/o about prior to this admission . Staff to offer toileting with rounding during nighttime hours . The I and A did not specify when the Resident was last toileted, what type of footwear they were wearing, continence status, if the call light was on, and/or when they were last observed by staff. - 5/22/25 at 10:00 PM: Fall . Resident Room . Resident was found on the floor between the half wall and bed on back with head at the end of bed with bilateral knees bent in the air. Resident description: Resident was trying to go to the restroom . Immediate Action Taken: Resident assessed for injury, none at this time . assisted into wheelchair X2 staff . Resident assisted to common area for closer supervision. Staff to assist guest to bathroom frequently and encourage out of room activities for closer supervision . Injury Type: Reddened Skin: Top of Scalp . Unable to Determine: Top of Scalp . No Injuries Observed Post Incident . The I and A did not specify when the Resident was last toileted, what type of footwear they were wearing, continence status, if the call light was on, and/or when they were last observed by staff. - 5/28/25 at 5:20 AM: Observed on floor . Nursing Station . Patient was observed on the floor by recliner that sits by nursing station. Patient was previously observed lying in recliner and later toileted at 4:35 AM. After patient was then placed back into recliner and shortly morning medications were passed at 5:09 AM. At 5:20 MA, patient was then observed on the floor laying on back with legs flexed towards body . arms were by side and head lying on floor. Patient was then observed for any immediate injuries and ROM was attempted. Patient did complain of pain in their right hip. Patient was then placed into wheelchair and further assessed for injuries which non were noted . Resident Description: Patient stated was trying to place blanket into the recliner . Immediate Actions Taken: Patient was observed for any injuries,,, Staff to assist (Resident) to keep a blanket in place while in the recliner . Level of Pain: 5 (out of 10, with 10 being the worst possible pain) . The I and A did not specify where staff were at the time of the fall, what type of footwear the Resident was wearing, continence status, if they had a call light and/or bell available, if they had a blanket covering them previously, and/or where the blanket was. An interview and review of Resident #14's I and A forms were completed with the Acting Director of Nursing (DON) on 6/13/25 at 10:15 AM. The fall on 5/15/25 was reviewed. When queried what time Resident #14 was last toileting, what type of footwear they were wearing, and when they were last seen by staff, the DON indicated that information would probably be in the facility investigation and not the I and A form. When asked why the investigation documentation was not provided when requested, the DON responded that they were unaware it had been requested. Any investigation documentation pertaining to Resident #14's falls were requested again at this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of received Post Fall Evaluation form for Resident #14's fall on 5/15/25 indicated the Resident was wearing gripper socks and was continent at the time of the fall. The post fall form designated the Root Cause of the fall was confusion and the initial intervention was to Keep residents w/c next to bed at night in case they attempt to get up. The intervention after IDT (Interdisciplinary Team) review was, Offer toileting during nighttime hours. A statement from Certified Nursing Assistant (CNA) N was included which specified, Worked from 10PM to 6AM. Just observed resident in bed prior to fall doing check/change. Toileting offered and declined. The DON was asked if Resident #14 had been offered and declined toileting approximately 15 minutes prior to the fall on 5/15/25, per the documentation, the DON confirmed. When asked if the Resident was sleeping and woke up by the CNA during their check and change rounds, the DON was unable to provide a response. When queried how the intervention of offering toileting during the nighttime hours was a meaningful intervention to prevent future falls when they had been offered and declined toileting 15 minutes prior to falling, the DON did not provide an explanation. When queried if the call light was on, the DON confirmed the documentation did not say and verbalized Resident #14 does not really use their call light because of their confusion. Review of received Post Fall Evaluation form for Resident #14's fall on 5/22/25 revealed the Resident had an unobserved fall at 10:20 PM in their room while trying to go to the bathroom. (Note: The I and A specified the fall occurred at 10:00 PM). The Resident had gripper socks in place and was incontinent at the time of the fall. Per the Post Fall form, Resident #14 was last seen at 10:00 PM during check and change rounds and were dry at that time. The Post Fall Evaluation specified the root cause of the fall was Alarm and initial interventions to prevent further falls included Staff to assist to common are when awake, toilet frequently, Red tape over call light so guest will use it . New Intervention after IDT review included increased opportunity for observation and socialization . There were no staff statements included. The DON was asked if Resident #141 had an alarm in place on 5/22/25 and responded they did not. When asked why the Post Fall Evaluation specified the root cause of the fall was an alarm, the DON indicated it must have been an error. When queried how a meaningful intervention was implemented when the root cause of the fall had not been accurately identified, the DON did not provide a response. When asked what intervention the facility implemented following this fall, the DON verbalized the Resident was to be placed near the nurses' station where they were able to be observed by staff when they were awake. When queried regarding the time discrepancy of the fall, 10:00 PM or 10:20 PM, an explanation was not provided. Review of the Post Fall Evaluation form for Resident #14's fall on 5/22/25 revealed the Resident had an unwitnessed fall while sitting in the recliner chair by the nurses' station at 5:20 AM. The Resident was wearing gripper socks and was continent at the time of the fall. The Post Fall Evaluation indicated the Resident was last observed at 5:09 AM when their morning medications were administered. The initial intervention to prevent future falls was keeping patient entertained and the intervention following IDT review was Staff to assist (Resident) to stay covered when in recliner. The Re-Creation of Last 3 Hours Before Fall section of the Post Fall Evaluation specified: - 4:20 AM: Patient was observed lying in recliner. - 4:35 AM: Patient was attempting to self-transfer . was taken to the bathroom . was continent . placed back in recliner. - 5:09 AM: Patient was lying in recliner and given morning medication. - 5:20 AM: Patient was observed on floor lying on back. ROM was attempted . complained of slight pain in right hip pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation documentation included a single typed page which included: - 5/28/25 Interview with (Licensed Practical Nurse (LPN) L) . Guest was resting in the recliner during the nighttime hours and was toileted at 4:35 AM . continent at that time. (Resident #14) was transferred back into recliner by the nurses' station. At 5:09 AM, morning medication were given and continued to remain in the recliner. At 5:20 AM, during morning med pass, guest was observed on the floor lying on back next to recliner. Guest assessed for injury, did complain of slight right hip pain, not abnormalities noted lite hip rotation or shortening of the leg. Guest was transferred into wheelchair using two assist with gait belt. Guest has gripper socks on. Guest stated, 'I was trying to put by blanket back on the chair . 5/28/25 at 7:00 AM: (Acting DON) observed Resident #14) in wheelchair sitting next to nurse's med cart . was eating breakfast . 5/28/25 (no time) Based on incident report and initial complaints of pain in right hip, x-rays ordered to R/O (rule out) fracture. The typed sheet of paper was not signed by LPN L nor the Acting DON, did not have a time that LPN L's interview was completed, and did not specify who completed the interview. The DON was asked why Resident #14 had been sitting in the recliner at the nurses' station at approximately 4:20 AM and revealed Resident #14 had a rough night and the staff placed them in the recliner to keep an eye on them. The DON indicated LPN L told them they had sat by the Resident because Resident #14 was restless that night. When queried where the staff were when the Resident fell, the DON stated, They probably went to the med cart and indicated LPN L would have had other resident's medications to pass. When asked if staff would be able to see the Resident from the medication cart, the Acting DON responded they would not. When queried regarding the root cause of the fall, the DON stated, (Resident #14) tried to pull the blanket up. When asked where the blanket was and if the Resident had been covered with the blanket the last time they were observed by staff, the DON was unable to provide a response. When queried if the Resident had a call light and/or bell to contact staff while sitting in the recliner, the DON replied, No. The DON was asked why the Resident #14 was left alone and unsupervised by staff when they had been placed in a recliner at the nurses' station so staff could be directly supervised, a response was not provided. When asked about the increased risk of leaving Resident #14 alone and unattended with no method of contacting staff for assistance, the DON stated, Well better than to leave them alone in their room. When asked how it was better as the Resident fell and suffered a hip fracture, an explanation was not provided. The DON was asked why another staff member did not come sit with the Resident so LPN L could go and pass medications to other residents, an explanation was not provided. When queried how many staff were working that night and their location at the time of the fall, the DON responded that they did not know. The DON was asked if the facility had sufficient staffing levels on the date and time of the fall to provide adequate resident supervision and responded they were unaware of the facility being short staffed. The facility clock in sheets for the midnight shift on 5/27/25 to 5/28/25 were requested at this time. Review of facility provided Employee Assignment Sign -In Sheet for the midnight shift on 5/27/25 revealed the facility Census was 137 residents. There were six nurses, and seven CNA's scheduled. On Resident #14's unit, two nurses and three CNA's were scheduled but one CNA was identified as a NCNS (No Call No Show). An interview was completed with Scheduler O on 6/13/25 at 3:00 PM. When queried regarding staffing levels for midnight shift on Resident #14's unit, Scheduler O revealed that was the largest unit in the facility and stated, Three CNA's and 3 nurses.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #70 On 6/10/25 at 1:13 PM, an interview was completed with Resident # 70 in their room. The Resident was sitting up in their bed with the overbed tray positioned over the bed in front of them. A nebulizer machine was present on the dresser beside the bed. The nebulizer mask was sitting directly on the top of the dresser and was not contained. There was visible fluid in the medication cup chamber of the nebulizer mask. Record review revealed Resident #70 was admitted to the facility on [DATE] with diagnoses which included bipolar disorder, depression, anxiety, and colostomy (surgically created opening in the abdomen allowing for the passage of stool into an external bag). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to substantial assistance to complete Activities of Daily Living (ADLs) with the exception of set-up assistance for eating and oral hygiene. Review of Resident #70's care plans in the Electronic Medical Record (EMR) revealed the Resident did not have a care plan and/or intervention in place related to nebulizer use and/or treatments. An interview was completed with the Acting Director of Nursing (DON). When queried regarding observation of nebulizer mask in Resident #70's room with fluid in the medication cup /chamber, the DON stated, Should be cleaned after use and indicated the nebulizer mask should be separated and left out to dry. Based on observation, interview and record review, the facility failed to ensure appropriate storage and labeling of respiratory devices for five residents (R12, R50, R70, R392 and R397) of six residents reviewed for respiratory care. Findings include: Resident #12 R12 is [AGE] years old and re-admitted to the facility on [DATE] with diagnoses that include unspecified asthma, chronic obstructive pulmonary disease (COPD), shortness of breath and generalized anxiety. On 06/10/25 at 02:00PM, observation revealed a nebulizer t-bar at the bedside with fluid in the medication chamber. On 06/11/25 at 01:59PM, observation revealed a nebulizer t-bar next to the bed with fluid in the medication chamber. These findings were verified with Unit Manager (UM) G that there was fluid in the medication chamber of the nebulizer. UM G was asked when was the last time R12 received a nebulizer treatment. UM G stated that R12 is no longer receiving nebulizer treatments. UM G removed the t-bar and nebulizer machine from the room at this time. On 06/11/25 at 02:37PM, record review revealed a physician's order for ipratropium-albuterol, 3ml inhale orally three times a day for shortness of breath and wheezing. This order was for 5 days and was discontinued on 6/3/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #50 R50 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include COPD, shortness of breath, depression and acute kidney failure. On 06/10/25 at 11:59AM, observation revealed a nebulizer next to the bed on a bedside table. Fluid is observed in the medication chamber. R50 stated they got a treatment one time, but it stopped working after a few minutes and they never got another and that was on 06/07/25. On 06/11/25 at 09:47AM, observation revealed a nebulizer next to the bed on a bedside table. Fluid is observed in the medication chamber. Record review revealed that R50 last received a nebulizer treatment on 06/07/2025. On 06/11/25 at 01:55PM, the findings of the nebulizer were verified with UM G. UM G noted there was fluid in the medication chamber. UM G was asked what the nursing staff should do with the nebulizer equipment when the treatment is complete. UM G stated that the nurse should separate the components, clean them and lay them on a paper towel until they are dry and then store them in a bag. Resident #392 R392 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include COPD, cough, acute and chronic respiratory failure and heart failure. On 06/10/25 at 02:31PM, observation revealed that R392 was receiving 5L of oxygen via a nasal cannula, there was no label and date located on the tubing. On 06/11/25 at 01:51PM, UM G was asked if the facility labels oxygen tubing. UM G stated yes, we label it, UM G showed this surveyor where the label should be located on the oxygen tubing, there was no label present. On 06/11/25 at 02:20PM, an interview was conducted with UM G. UM G was asked what the procedure is for labeling and dating of oxygen tubing. UM G stated, we have an oxygen company that comes to the facility once a week on Wednesday. They change and label the tubing. UM G was asked why there wasn't a label on the oxygen tubing currently and what do you do with residents on oxygen on admission. UM G stated, there is no label on it currently, he just admitted on [DATE], the staff would label it on admission. It has not been a week yet, but the staff should have labeled and dated it on admission. Resident #397 R397 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic heart failure, acute respiratory failure, atrial fibrillation and fluid overload. On 06/10/25 at 12:43PM, observation revealed a nebulizer on the bedside table with fluid in the medication chamber. On 06/11/25 at 09:04AM, observation revealed a nebulizer on the bedside table with fluid in the medication chamber. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the policy titled, Nebulizer Therapy, Small Volume, revealed, Implementation: -Rinse the nebulizer with water and allow it to air-dry. Alternatively, discard it after the treatment. Record review of the policy titled, Use of Oxygen, revealed, I. The O2 cannula or mask should be changed weekly and dated. It should be changed when soiled or dirty.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to timely respond to two residents' (#28 and #47) pharmacy recommendations of five residents reviewed for unnecessary medications. Findings Include: Resident #28: On 6/13/2025 at 9:30 AM, a review was conducted of Resident #28 medical records, and it indicated she readmitted to the facility on [DATE] with diagnoses that included, Chronic Respiratory Failure, Major Depressive Disorder, Adjustment Disorder, Anxiety and Gastro-Esophageal Reflux Disease. Further review was conducted and yielded the following: On 6/13/2025 at approximately 10:45 AM, a review was conducted of Resident #28's Medication Regime Reviews (MRR) from August 2024 - May 2025. The following was found: January 13, 2025: (Resident #28) receives Eliquis 5 mg BID and Aspirin Low Dose 81 mg daily. Her last HBG is noted at 8.543 on 1-3-25. Please reevaluate the continued use of their combination therapy and perhaps stop using ASA therapy . Practitioner B accepted the recommendation above with modifications on 1/15/2025, Will discuss with patient and adjust the treatment. May 8, 2025: The resident has received a H2R2, famotidine 20 mg twice daily, which may increase risk of adverse effects (e.g., confusion). Please decrease to maintenance dose of famotidine 20mg once daily at bedtime. Practitioner B disagreed with the recommendation on 5/10/2025 and provided the following rationale GDR (gradual dose reduction) was done and ineffective, continue current treatment plan. January 2025 MAR (Medication Administration Record): Aspirin EC Tablet Delayed Release 81 MG- give one tablet by mouth one time day for Heart Health. Started on 10/11/2024 and discontinued on 1/17/2025. Aspirin Oral Tablet- Give 81 mg by mouth one time a day for prophylactic. Ordered on 1/30/2025 and discontinued on 6/11/2025. May 2025 MAR: Famotidine Oral Tablet 20 MG - Give one tablet by mouth two times a day for GERD. Ordered on 1/29/2025. On 6/13/2025 at 11:57 AM, Resident #28 shared prior to admission she only took famotidine (Pepcid) once a day. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/2025 at 12:05 AM, review was completed of the MRR for GDR of Pepcid for with the DON (Director of Nursing). The DON was asked when the GDR was completed and for the documentation that it was unsuccessful. The DON confirmed a GDR was not completed on Pepcid and stated the response could have been worded better. The DON was asked why there was delay in discontinuing the resident's usage of Aspirin after the recommendation was agreed with in January 2025. The DON reported she did not know why there was delay. On 6/13/2025 at 12:10 PM, Practitioner B stated there was not a GDR completed on Resident #28's Pepcid but she has a history of gastrointestinal bleed and low hemoglobin. The Pepcid order was based on the order from when she returned from the hospital in January 2025. Resident #28 was still receiving Aspirin as the facility discontinued the medication on 1/17/25 but shortly after she had a hospital stay and upon return, they restarted the medication on 1/30/2025. Resident #47: On 6/13/25 at approximately 11:35 AM, a review was conducted of Resident #47's medical record and it revealed he was admitted to the facility on [DATE] with diagnosis that included, Diabetes, Anxiety Disorder, Chronic Kidney Disease, Hypertension, Bipolar Disorder and Dementia. Further review was completed and yielded the following: Review was conducted of Resident #47's Medication Regime Reviews (MRR) from August 2024 - May 2025 and the following was found: April 15, 2025: This resident frequently requires insulin pers sliding scale. Please consider increasing the Humalog to 13u with meals. Rationale for Recommendation: Prolonged use of sliding scale insulin is not recommended as it often results in wide variations in blood glucose, increased prolonged periods of hyperglycemia or hypoglycemia . Practitioner B signed the recommendation on 4/16/2025 and stated, Will discuss with the patient and adjust Humalog dose and discontinue ISS (insulin sliding scale). Physician Orders: Humalog Injection Solution 100 Unit/ML -inject 10 unit subcutaneously with meals for DM II in addition to sliding scale. Initiated on 01/06/2025 and discontinued on 6/12/2025. The recommendation the practitioner agreed with on 4/16/2025 was not completed until two months after. Progress Notes: 4/21/2025 at 00:00: .Blood sugar reviewed in (medical chart) with the trending in 200?s. He feels depressed and would like to discussed about medications .Continue Glargine 26 U at HS and Humalog 10 U TID with meals and ISS. Discussed with the patient about blood sugar runs in 200?s and calorie control. Monitor Blood sugar . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/2025 at 11:05 AM, Unit Manager C was asked why it took two months to update Resident #47's insulin order based on the pharmacy recommendation Practitioner C agreed with. Manager reviewed the subsequent documentation and stated she was unsure why it took that long to adjust as indicated. On 6/13/2025 at 1:40 PM, an interview was conducted with Practitioner B regarding Resident #47's regime review. She reported she signed the regime review with her intentions prior to discussing the changes with the resident. After speaking with the resident, he wanted to make changes to diet and it was decided to maintain his current insulin regime. It was expressed the change was never indicated within the progress note or on the regime review. Review was completed of the facility policy entitled, Timeliness of Medication Regimen Review (MRR) Reports, revised 9/7/2023. The policy stated, .The attending physician is expected to review the resident's individual MRR and document and sign that he/she has reviewed the pharmacist's identified recommendations within 14 days of receipt . The policy does not address the process or timeliness of acting upon the MRR's (if agreed with).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235666	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Grand Blanc	1330 Grand Pointe CT Grand Blanc, MI 48439

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure policies and procedures were operationalized for safe bedside medication storage for two residents (# 70 and # 81) of two residents reviewed resulting in a lack of assessment for self-administration of medications, medications stored at bedside, and lack of staff knowledge of medication administration. Findings include: Resident #70: Record review revealed Resident #70 was admitted to the facility on [DATE] with diagnoses which included bipolar disorder, depression, anxiety, and colostomy (surgically created opening in the abdomen allowing for the passage of stool into an external bag). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to substantial assistance to complete Activities of Daily Living (ADL) with the exception of set-up assistance for eating and oral hygiene. On 6/10/25 at 1:13 PM, an interview was completed with Resident # 70 in their room. The Resident was sitting up in their bed with the overbed tray positioned over the bed in front of them. A bottle of over-the-counter migraine pain relief and a tube of hydrocortisone cream (steroid cream) was sitting on the overbed table. When queried regarding the medications on their overbed table, Resident #70 replied they put it on their ear on night because of a rash and itching. On 6/11/25 at 2:45 PM, Resident #70 was observed in their room in bed. An interview was completed at this time. When asked how they were doing, Resident #70 revealed they were upset because they took my bottle of Excedrin (over-the-counter migraine pain reliever) away. When queried if they were taking the Excedrin, Resident #70 stated, I would take two in the morning and two in the afternoon so once or twice a day. When asked if they have migraines, Resident #70 responded that they don't. Resident #70 verbalized they take it for pain and indicated it is the only thing that helps them. When asked if they receive pain medication at the facility, Resident #70 stated, I get Tylenol here too. Resident #70 then stated, I have had it (over the counter migraine pain reliever) in here a couple months, and nobody said anything about it. It was right here (pointed at their overbed table). An interview was completed with the Acting Director of Nursing (DON) on 6/12/25 at 9:14 AM. When queried regarding the facility policy/procedure related to resident self-administration of medications, the acting DON stated, We wound do a self (medication administration) assessment and give them a lock box to keep the medications in in their room. When queried regarding observations of Resident #70 having medications in their room and the Residents statements regarding the medications, the acting DON stated, (Resident #70) should not have meds at bedside. I will talk to (the Resident). Resident #81: (continued on next page)

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	235666	A. Building B. Wing	06/13/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #81 was admitted to the facility on [DATE] with diagnoses which included heart disease, arthritis, and falls. A review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired. On 6/12/25 at 9:59 AM, Resident #81 was observed sitting in the recliner in their room with their eyes closed. A 3-ounce (oz) roll on container of Biofreeze (topical pain relief gel used for temporary minor muscle and joint pain relief) and several 3 milliliter (mL) individual packets of Biofreeze were sitting on the overbed table in front of the Resident. At 10:01 AM, the Acting DON was observed walking in the hallway of the facility and an interview was completed at this time. When asked if Biofreeze is considered a medication, the DON replied, Yes. When asked if Resident #81 was able to self-administer medications, the DON stated, No. The DON was then asked why there was Biofreeze on Resident #81's bedside table and stated, (Resident #81) shouldn't. A review of Resident #81's EMR revealed the Resident did not have a care plan and/or assessment in place related to self-administration of medications. A policy/procedure related to medication storage was requested from the facility Administrator on 6/11/25 at 4:39 PM but not received by the conclusion of the survey. A policy/procedure related to self-medication administration by residents was requested from the DON on 6/12/25 at 9:14 AM but not received by the conclusion of the survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to 1) Maintain food preparation and kitchen equipment in a sanitary and good working condition and 2) Maintain a clean and sanitary environment (refrigerator, microwave and floor drains), resulting in an increased potential for food borne illness, with the potential to affect all residents who consumed oral nutrition. Findings Include: On 6/10/25 at 10:28 AM, a tour of the kitchen was completed with Certified Dietary Manager D the following was identified as areas of concern: Ice Machine: Puddle of water was observed being the ice machine. The drain grate was a dark orange/brown color on the slacks. The tubing from the back of the ice machine the filter connected on the wall was riddled with visible brown colored dust spanning the length of the tubing. Microwave: The inside of the door, sides and top of the microwave were splattered with unknown food particles. Cooks Refrigerator: Both corners of the refrigerator had dried food particles and smudges in various areas on the outside and inside of the door. Cereal Dispenser: The three cereal chutes for [NAME] Krispies, Corn Flakes, and Cheerios had a film of debris. Tray Line refrigerator: The seal on the right door is not secured to the door. There was ice/frost build up at the top of the refrigerator The drain/grate underneath the sink (closet to the stove) was soiled with brown/dark orange residue. Three- crates of ready to use cups (about 75 cups) were resting against a soiled step stool. Three -ready for use baking sheets were wet. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Walk-in Freezer: Ice/frost build up on the fan blades Staff were observed actively washing dishes and for proper wash and sanitization It took eight racks for the final rinse temperature to reach 180°. Dishwasher F reported prior to they had already washed four warming carts that were full of dirty dishware. On 6/11/2025 at 2:30 PM, CDM D stated the ice machine does not have a leak, but the machine was not lined up with the drain, and the water was not draining into the appropriate area. She stated the puddle of water should not have been there. On 6/11/2025 at 2:40 PM, Environmental Services Director E reported the drain covered behind the ice machine and underneath the side sink is plastic, and he will see if they are able to be removed and cleaned. He reported since his inception that is not task that he or his staff have completed. Dish Machine High Temperature Logs June 2025: Review was completed of June 2025 dishwashing temperature log and at the bottom it stated, Rinse Temp: Minimum 180° Rinse 6/1/2025: 160° 6/2/2025: 160° 6/4/2025: 170° 6/8/2025: 170° There were no subsequent notes or documentation related to the dates above and what action was taken when the final rinse was not at the minimum temperature of 180°. Dishwasher Reactive Service Call Summary Receipt dated 6/10/2025: Notes to customer: On the dish machine for final rinse state came through and they said it took him eight racks to get it over 180° so I made an adjustment and now it stops at 190°. It only took me three racks to get there . Review was completed of the facility policy entitled, Dietary Cleaning and Sanitation, revised 11/12/2021. The policy stated, It is the policy of this facility to maintain the sanitation of the kitchen through proper cleaning and sanitizing station food service equipment .