STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235703	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor Nursing and Rehabilitation Center LL	50 N Perry St, 1st Floor Pontiac, MI 48342

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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 - Many	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. Based on observations, interviews, record review the facility failed to ensure medication and treatment supplies were secured to prevent unauthorized access, as evidence by an unlocked treatment cart accessible in-patient care area. Findings include:On 1/26/26 at 8:44 AM, the facility medication treatment cart was observed unlocked and unsecured across from the nurse's station. On 1/26/26 at 9:18 AM, the medication treatment cart was observed unlocked. Nurse E was interviewed and asked should the treatment cart be locked, Nurse E reported yes and proceeded to lock the cart. On 1/26/26 at 1:32 PM, the facility's medication treatment cart was observed unlocked and unsecured across from the nurse's station. On 1/27/26 at 8:21 AM, the facility's medication treatment cart was observed unlocked and unsecured across from the nurse's station. On 1/27/26 at 12:03 PM, the director of nursing (DON), was interviewed and asked should treatment carts be locked when unattended the DON reported the carts should be locked. There was no additional information provided at the exit of survey.

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an ongoing resident-centered activities program to provide meaningful activities per resident preferences to support their physical, emotional, cognitive, and psychosocial well-being for five residents (R6, R9, R10, R15 and R30) of five residents reviewed for activities. Findings include:Review of the resident census upon survey entry was 21 residents, confirmed by the Nursing Home Administrator (NHA) / Director of Nursing (DON), who assumed both roles upon hire, on/ near 1/09/26. On 1/26/26 at approximately 10:05 a.m., the NHA/DON described upon entry that the facility was a sub-acute short-stay rehabilitation unit (facility). It was clarified there were only two long-term care residents at the facility, R2 and R3, who would mainly require activities. When asked about resident council, the NHA/DON explained they had no resident council president, as there were no resident council meetings in the facility. This Surveyor asked to speak with the Activity Director for clarification on the resident council process. The NHA/DON reported they had no Activity Director or any activity staff. The NHA/DON clarified the Certified Nursing Aides (CNAs) were completing activities with the residents. Review of the provider description revealed the facility was a 29 bed SNF/NF facility, which meant all the beds (including the resident census of 21 residents) were subject to the regulatory guidance requirements for the provision of an Activity Director, who would be expected to oversee an active ongoing activities program. R6 On 1/26/26 at approximately 11:55 a.m., the unit was observed for an activity calendar, with none observed. The nursing staff confirmed there was no activity calendar, and there had not been for at least a few months. On 1/26/26 at 11:58 a.m., R6 was observed in their room, seated upright in their wheelchair, with a pack of crayons on their bedside table. R6's room had no activities present, such as puzzle books, coloring pages, crafts, magazines or evidence of any activities. There was no activity calendar observed in R6's room. On 1/26/26 at 12:00 p.m., R6 said their daughter brought them the crayons. R6 said they would like some activities such as word searches, puzzle books, and coloring pages, and wished they had activities to attend such as BINGO, parties, etc. R6 stated their only activity was therapy and staff were not doing any activities with them. R6 believed there should be activities available, and said their daughter was going to bring them coloring pages. R6 reported this concerned them. R6 shared they would be at the facility longer than expected, until they saw a neurologist regarding their difficulty standing and walking, so having activities was important to them. Review of the Electronic Medical Record (EMR) revealed R6 was admitted to the facility on [DATE]. On 1/26/26 at 4:36 p.m., CNA I was asked if they had been asked by facility management to provide activities to residents by facility management. CNA I reported they were a newer hire this month and said they had not been educated in their orientation or after to provide activities to facility residents. Surveyor asked if there was any charting for their residents to complete activities. CNA I confirmed (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was no charting for complete activities with the residents. CNA I shared they had not seen activities being provided to facility residents when asked however said they had played cards with one resident who had asked them. R15 Review of R15's Minimum Data Set (MDS) assessment, dated 1/15/26, showed they were admitted to the facility on [DATE]. The assessment showed R15 had cognitive impairment. Review of R15's profile revealed they had diagnoses including metabolic encephalopathy (brain dysfunction from metabolic causes), dementia, heart disease, kidney disease, a fall with a fractured clavicle, and a history of hip replacements. Review of R15's Care Plan, accessed 1/27/26 at 5:29 p.m., revealed no activity problems, goals or interventions. The care plan revealed R15 required significant assistance for toileting, bed mobility, transfers, and further revealed R15 became agitated with care and had care refusals at times. On 1/26/26 at 1:28 p.m., R15 was observed in the hallway across from the nurse's station, seated in their high back wheelchair, staring ahead. R15 was asked how they were doing and said they wanted to talk to their wife. Nursing staff were made aware. There were no activities on the unit or nearby. On 1/26/26 at approximately 4:45 p.m., R15 was observed seated across from the nurse's station on the unit in their recline high back wheelchair, with an empty tray table and water on their side. R15 was asked how they were doing. R15 said they wished they could go fishing and wanted to be with their family. R15 was asked if they would participate in activities if available, smiled, and said they liked to fish. R15 said, I like to keep busy, and said they wished they had something to do. There were no activities on the unit or nearby. On 1/27/26 at 9:27 a.m., R15 was observed seated upright in their high back wheelchair again in the hallway across from the nurse's station, with a tray table other with only a Styrofoam cup next to the them. There were no activities on the unit or nearby. There was no activity calendar on the unit which nursing staff confirmed. On 1/27/26 at 9:28 a.m., R15 was asked how they were doing. R15 said they were doing fine, but said they liked to move around. When asked what they would like to do, R15 said they liked music activities and magazines for fishing and travel since they liked to travel. R15 was asked about their vision (to see magazines) and said it was very good. R15 also said they liked to go to church and play games and cards also. R15 clarified their hobbies in life had been tennis, bowling, fishing, and said they enjoyed going out. R15 said, It is boring (here). On 1/27/26 at approximately 9:30 a.m., CNA J was observed to approach R15, and asked if they were ok, R15 said they were fine, and CNA J left. No activities were provided. On 1/27/26 at 10:09 a.m., R15 was observed seated in their wheelchair outside their room, across from the nurse's station, with no activities or staff completing activities with them. LPN D was at the nurse's station during the observation. On 1/27/26 at approximately 10:11 a.m., Licensed Practical Nurse (LPN) D was asked about activities being done with residents at the facility. LPN D said since most residents were there on a (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	short-term stay, they did not think it was a priority. LPN D said R2 and R3 were the only long-term care residents at the facility. LPN D was asked if they had any concerns with residents not receiving activities. LPN D said they sometimes gave residents coloring sheets, newspapers, or magazines however said there were no activity staff providing them. LPN D was asked if any of the CNAs were completing activities with the facility residents. LPN D responded, No. LPN D was asked if residents should have been receiving activities. LPN D stated, Yes, in the afternoon, things slow down after lunch and after lunch would be a good time to have activities. Yes, that would be beneficial to give them something to do. And it might prevent falls and prevent them from being restless. Arts and crafts, BINGO.Mostly residents are just watching TV (television). Review of the EMR showed R15's EMR showed R15 had three falls since their admission, on 1/10/26, 1/23/26, and 1/25/26. On 1/27/26 at 10:42 a.m., R15 was observed seated in their wheelchair across from the nurse's station, appearing drowsy, with the tray table with water on their right side, with no magazines or activities observed. There were no activities observed on the unit or nearby. On 1/27/26 at 11:09 a.m., R15's Family Member, FM S, was asked during a phone interview if they believed R15 could participate in an activities program if there was one at the facility. FM S responded, Yes. As long as they could work with his dementia. FM S clarified R15 was being discharged home soon and said they would provide R15 with activities at home. On 1/27/26 at 11:55 a.m., and 12:00 p.m., R15 was observed seated outside their room across from the nurse's station in their wheelchair, awake, with their tray table with water only, not participating in activities. There were no activities observed on the unit or nearby. On 1/27/26 at approximately 12:02 p.m., R15 was asked how they were doing. R15 said they had nothing to do. On 1/27/26 at 2:57 p.m., R15 was observed in their bed, awake, with no activities in their room including puzzle books, color pages, or magazines. Their room was empty and bare, and there was no activity calendar in their room. On 1/27/26 at 4:51 p.m., R15 was observed in their wheelchair seated outside their room at the nurse's station, with no activities on their empty tray table. There were no activities on the unit or nearby. On 1/28/26 at 1:24 p.m. R15 was observed in their wheelchair outside their room, across from the nurse's station. Their empty tray table was in front of them. There were no activities on the unit. There were four nursing staff at nurse's station. Review of the EMR showed a nursing progress note, dated 1/26/26 at 4:19 p.m., which revealed, (R15) has become agitated since wife left facility. (Physician T) recommended Seroquel 25 mg (an anti-psychotic medication) for agitation or anxiety. R9 On 1/26/26 at 11:49 a.m., R9 said when they were in their wheelchair, There is nothing to do . and stated this bothered them. R9 was asked if they would participate in activities if available; R9 said (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they would. When asked what they would like to do, R9 said they wanted more to do, and did not explain further when asked. On 1/27/26 at 10:25 a.m., LPN H was asked about R9 and their ability to participate in activities. LPN H said R9 had a disability and had just a little cognitive impairment. LPN H said they made sure R9's TV was on for them. LPN H said when R9 was sitting in the wheelchair in the hallway, they would want to get back in bed to watch TV. On 1/27/26 at 10:30 a.m., LPN H was asked if there were any activities being provided by facility staff, including CNAs. LPN H said the aides were not providing activities to the residents. LPN H stated, .I believe that they (the facility) should be having like a devotional or news printed out and even crossword puzzles.They (residents) do not do any coloring pages. LPN H said nursing staff tried to keep the residents entertained by talking with them. LPN H clarified, They (the residents) are sitting there bored and their TV (television) on. I don't think anyone wants to sit there and just watch TV . LPN H said physical therapy got the residents moving but otherwise there were no activities going on in the facility. On 1/27/26 at 4:52 p.m., R9 was observed in their wheelchair, seated across from the nurse's station. R9 was observed rocking back and forth at the hips; no activities were observed around them. R9 was asked how they were doing and said they had nothing to do. There were no activities around them or going on in the facility. On 1/28/26 at 1:24 p.m. R9 was observed seated next to R15 in their wheelchair outside their room, across from the nurse's station. Their empty tray table was in front of them. There were no activities on the unit or nearby. There were four nursing staff at nurse's station. Review of R9's MDS assessment, dated 12/29/25, revealed R9 scored as cognitively intact, with no behaviors, symptoms of depression, psychosis, or rejection of care. R9 was able to feed themselves and required maximal assistance with bed mobility and transfers. Review of R9's profile revealed R9 was admitted to the facility on [DATE], with diagnoses including sepsis (severe systemic infection), pulmonary embolism (lung blood clot), and schizophrenia (a mental disorder which may have psychotic features). The profile showed R9 had a guardian. Review of R9's Care Plan, accessed 1/28/26 at 8:44 a.m., revealed R9's discharge plan was to return to the community upon discharge. Review of R9's progress notes showed they were at the facility for short-term rehabilitation and had lived in supported housing in the community prior to being at the facility. R10 On 1/27/26 at 9:37 a.m., R10 was observed lying in their hospital bed. On 1/27/26 at 9:39 a.m., R10 was asked if they would participate in activities if offered. R10 said they would participate in select activities when able, including attending a music event, bowling, BINGO, or playing cards if it was offered. R10 said they were working through back pain and were at the facility for therapy. R10 was alert and oriented to themselves, situation, and place. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/26 at 2:55 p.m., R10 was in their room, seated in a chair. R10 was asked how they were doing and responded, I am bored. Review of R10's face sheet revealed R10 was admitted to the facility on [DATE] with diagnoses including compression fractures of vertebra (back bones), sepsis, and metabolic encephalopathy. Review of R10's Care Plan , accessed on 1/28/26 at 12:20 p.m., revealed R10 required one-person assistance with toileting and transfers and planned to return to the community with the support of family members. The behavioral Care Plan showed R10 had behaviors of agitation and restlessness at times. Review of R6, R9, R10, and R15's Electronic Medical Records (EMR) revealed no activity assessment, activity logging, activity participation, or activity care planning including activity goals, interests, preferences, and abilities. Observations throughout the survey yielded no activity calendars on the resident unit, in common areas, the dining room, residents' rooms, which nursing staff confirmed. Observation throughout the survey yielded no group or individualized activities. On 1/27/26 at 11:42 a.m., NHA B said they had no documentation of their checking in with residents when they were the NHA at the facility prior to the current NHA. NHA B explained they were not aware of a binder. NHA B said they provided activity packets including word searches and trivia from a cart during the weeks when they were at the facility but had no documentation of these interactions. NHA B concurred there were no activities formally since August 2025, when the former Activity Director vacated their position. NHA B conveyed R5 had newly become a long-term care resident. On 1/28/26 at approximately 2:10 p.m., the current NHA, with NHA B present, reported they understood the concerns related to no current Activity Director since August 2025. Review of R6, R9, R10, and R15's Electronic Medical Records (EMR) revealed no activity assessment, activity logging, activity participation, or activity care planning including activity goals, interests, preferences, and abilities. Observations throughout the survey yielded no activity calendars on the resident unit, in common areas, the dining room, residents' rooms, which nursing staff confirmed. Observations throughout the survey yielded no group or individualized activities. Review of the Policy, Activities, revised 2/24/24, It is the policy of this facility to provide on ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both impendence and interaction within the community. Activities refer to any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence. Policy Explanation and Compliance Guidelines: 1. Each resident's interest and needs will be assessed on a routine basis. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review, the facility failed to ensure there was a qualified activity professional who directed and oversaw an ongoing activity program to ensure meaningful activities were provided consistently per resident preferences for four Residents (R6, R9, R10, and R15) of four residents reviewed. Findings include: Review of the resident census upon survey entry was 21 residents, confirmed by the Nursing Home Administrator (NHA) / Director of Nursing (DON), who assumed both roles upon date of hire, on/near 1/09/26. On 1/26/26 at approximately 10:05 a.m., the NHA/DON described upon entry that the facility was a sub-acute short-stay rehabilitation unit (facility). It was clarified there were only two long-term care residents at the facility, who would mainly require activities. When asked about resident council, the NHA/DON explained they had no resident council president, as there were no resident council meetings in the facility. This Surveyor asked to speak with the Activity Director for clarification on the resident council process. The NHA/DON reported they had no activity director or any activity staff. The NHA/DON clarified the Certified Nursing Aides (CNAs) were completing activities with the residents. Review of the provider description revealed the facility was a 29 bed facility, which meant all the beds (including the resident census of 21 residents) were subject to the regulatory guidance requirements for the provision of an Activity Director, who would be expected to oversee an active ongoing activities program. R6 On 1/26/26 at 11:58 a.m., R6 indicated they wished there were facility activities, such as BINGO, parties, word searches, coloring pages, and arts and crafts. R6 was alert and oriented to themselves, their situation, surroundings, and time. On 1/26/26 at 3:55 p.m., the Human Resources Manager, Staff R, was asked how long the facility was without an Activity Director and if any other staff had assumed the role or any activity job responsibilities. Staff R reported they had worked in their role as the Human Resources Manager for about two and a half years. Staff R stated, There is nobody in the position right now. There is a candidate we are looking at . Staff R was asked if there were any staff in the activity department currently providing activities to residents, such as an activity aide, therapy staff, or anyone working towards certification. Staff R responded, No.I have no knowledge of anyone else assuming that role. Staff R said they were recruiting to find an Activity Director however they had no open posted position for an activity aide or other activity staff. Staff R clarified the Resident Council meetings were part of the Activity Director's role when asked. Staff R stated the former Activity Director had been in their position from 1/04/22 until 8/04/25. Staff R confirmed there had been no Activity Director, activity staff, or activity aide since 8/04/25, as they solely had an Activity Director position posted. On 1/26/26 at approximately 4:05 p.m., Staff R was asked if there were any Certified Nurse Aides (CNAs) who had been acting in the role as activity aides. Staff R said they had no knowledge of anyone in the facility fulfilling this role. Staff R stated, It (an activity aide position) should always come through me. If there was a CNA (acting as an activity aide), we (human resources) would have given them (assigned) both roles (i.e. CNA and activity aide). So, there was no CNA in the (activity aide) role either. On 1/26/26 at 4:36 p.m., CNA I was asked if they had been asked by facility management to provide activities to residents by facility management. CNA I reported they were a newer hire this month and said they had not been educated in their orientation or after to provide activities to facility residents. Surveyor asked if there was any charting for their residents to complete activities. CNA I confirmed there was no charting for complete activities with the residents. CNA I shared they had not seen activities being provided to facility residents when asked however said they had played cards with one resident who had asked them. R15 On 1/26/26 at approximately 4:47 p.m., R15 was asked how they were doing. R15 was seated there across from the nurse's station with an empty tray table. R15 said they wished they could go fishing and be with their family. R15 was asked if they would participate in activities if available, smiled, and said, I like to keep busy. R15 explained they wished they had something to do. Nursing staff were on the unit when R15 shared this and no activities were provided. R15 was interviewable and was oriented to (continued on next page)

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	235703	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor Nursing and Rehabilitation Center LL	50 N Perry St, 1st Floor Pontiac, MI 48342

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	themselves and their surroundings. On 1/27/26 at 9:28 a.m., R15 was asked how they were doing, while again seated across from the nurse's station with an empty tray table. R15 said they liked to participate in tennis, bowling, and fishing, and enjoyed going out before coming to the facility. When asked what kinds of activities they would do, R15 said they liked music activities and magazines for fishing and travel since they liked to travel. R15 also said they liked to go to church sometimes and played games and cards also. R15 said, It is boring (here). No activities were provided or nearby. R9 On 1/26/26 at 11:49 a.m., R9 said, There is nothing to do . R9 said this bothered them. R9 was asked what they would like to do, R9 said they wanted more to do but was not specific. R9 was oriented to themselves and their surroundings. On 1/27/26 at 10:25 a.m., LPN H was asked about R9 and their ability to participate in activities. LPN H said R9 had a disability and had just a little cognitive impairment. LPN H said they made sure R9's TV was on for them. LPN H said when R9 was sitting in the wheelchair in the hallway, they would want to get back in bed to watch TV. On 1/27/26 at 10:30 a.m., LPN H was asked if there were any activities being provided by facility staff, including CNAs. LPN H said the aides were not providing activities to the residents. LPN H stated, .I believe that they (the facility) should be having like a devotional or news printed out and even crossword puzzles.They (residents) do not do any coloring pages. LPN H said nursing staff tried to keep the residents entertained by talking to them. LPN H clarified, They (the residents) are sitting there bored and their TV (television) on. I don't think anyone wants to sit there and just watch TV LPN H said physical therapy got the residents moving but otherwise there were no activities going on in the facility. On 01/27/2026 at 4:52 p.m., R9 was observed in their wheelchair, seated across from the nurse's station. R9 was observed rocking back and forth at the hips, with no activities were observed around them. R9 was asked how they were doing and said they had nothing to do. R10 On 1/27/26 at 2:55 p.m., R10 was in their room, seated in a chair. R10 was asked how they were doing and responded, I am bored. On 1/27/26 at 9:39 a.m., R10 was asked if they would participate in activities if offered. R10 said they would participate in select activities when able, including attending a music event, bowing, BINGO, or playing cards if it was offered. R10 said they were working through back pain and they were at the facility for therapy. R10 was alert and oriented to themselves, situation, and place. Review of R6, R9, R10, and R15's Electronic Medical Records (EMR) revealed no activity assessment, activity logging, activity participation, or activity care planning including activity goals, interests, preferences, and abilities. Observations throughout the survey yielded no activity calendars on the resident unit, in common areas, the dining room, residents' rooms, which nursing staff confirmed. Observation throughout the survey yielded no group or individualized activities, and no activity mediums were observed at these residents' bedsides. On 1/27/26 at 11:42 a.m., NHA B said they had no documentation of them checking in with residents when they were the NHA at the facility prior to the current NHA. NHA B explained they were not aware of a binder. NHA B said they provided activity packets including word searches and trivia from a cart during the weeks when they were at the facility but had no documentation of these interactions. NHA B concurred there were no activities formally since August 2025, when the former Activity Director vacated their position. NHA B conveyed R5 had newly become a long-term care resident. 0n 1/27/26 at 1:05 p.m., the Resident Council task questions were reviewed with R6, as they agreed to be interviewed and were alert and fully oriented. R6 said they wanted to attend the resident council meetings if they were offered, since they were staying longer at the facility for an upcoming neurology appointment related to their mobility challenges. R6 said the facility should have more social activities there, per their earlier interview. On 1/28/26 at approximately 2:10 p.m., the current NHA, with NHA B present, reported they understood the concerns related to no current Activity Director since August 2025. Review of the Job Description, Activities Director, Copyright 2023, Compliance Store, received from the NHA, revealed, Department: Activities. Reports to: Nursing Home Administrator. Reporting to this position: Assistant Activities Coordinator, Activity Assistants, Volunteer Coordinators, Beauty Shop Operators. Classification: Department Manager. Position Purpose: Plans, organizes, supervises, and directs all administrative (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and operational activities of the Activities Department.The Activities Director is responsible for directing the development, implementation, supervision, and ongoing evaluation of the activities program, designed to meet the social, psychosocial and therapeutic needs of the resident. This includes the completion and/or directing the completion of the activities component of the comprehensive assessment and contributing to and/or directing /delegating the contribution to the compressive care goals and approaches that are individualized to match the skills, abilities, and interests/preferences of each resident in compliance with Federal and State regulations. Directing the activities program included scheduling of activities, both individual and groups, implementing and or delegating the implementation of recreational, educational, cultural and arts and crafts programs, monitoring the response, reviewing and evaluating the response to the programs to determine if the activities meet the assessed needs of the resident, and making revisions as necessary. The Director ensures that scheduled program activities are carried out seven days per week. The Director will ensure each resident is offered at least one cognitive activity, two recreational activities, and three ADL (activities of daily living) activities daily. Activities are to be tailored to the residents unique requirements and skills. At least one individual activity is planned for residents who are unable or unwilling to participate in group activities daily. Oversees the transportation of residents to social activities programs inside and outside the facility.The Activity Director is responsible for overseeing the establishment of a Resident Council and responsible for its smooth operation and documentation.Prepares a monthly calendar of activities written in large print and posted in a prominent location that is visible to residents and visitors.Assess residents needs and develops resident activities goals for the written Care Plan. Encourages resident participation in activities and documents outcomes. Reviews goals and progress notes. Properly documents MDS (Minimum Data Set - Standardized Nursing Assessment) reports and progress notes. Obtains necessary equipment and supplies and provides for their accessibility through organized storage.Participates with the Administrator in developing a budget. Contributes to facility efforts to maintain and /or improve quality of care through participation in the following: Attends Care Plan meetings, serves as a member of the QAPI committee (Quality Assurance and Performance Improvement), serves as a member of the behavioral management committee, attends department head meetings, attends mandatory in-services, successfully completes the facility required training, and the Activity Director Licensure continuing education requirements.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an appropriate Geri-chair [reclining chair with wheels] for two (R3 and R30) of two residents reviewed for accommodation of needs. Findings include:R3On 1/26/26 at 9:01 AM, R3 was observed lying in bed. R3 was asked if she was able to get out of bed. R3 explained she wanted to get out of the bed, but she had not been up in a long time. R3 was asked if she used a wheelchair. R3 explained they would bring in a reclining chair and put her in that, but it had been a long time since she had seen it. No wheelchair or geri-chair were observed in R3's room.On 1/26/26 at 12:52 PM, R3 was observed sitting in a tan colored geri-chair in her room. R3 explained with a smile that it was the first time she had been up in a long time and she was happy. Review of the clinical record revealed R3 was admitted into the facility o 7/31/25 with diagnoses that included: metabolic encephalopathy, muscle weakness and need for assistance with personal care. According to the Minimum Data Set [MDS] assessment dated [DATE], R3 had moderately impaired cognition.R30On 1/27/26 at 12:40 PM, R30 was observed lying in bed eating lunch. A narrow, blue geri-chair was observed in R30's room, on the opposite side of the room. The chair was observed to have tape on both arm rests, and a rip in the fabric on the right arm rest. R30 was asked if he ever sat up to eat. R30 explained he had sat in a wheelchair, but he kept sliding out, so they had put him in a geri-chair. R30 was asked if he used the blue chair on the other side of the room. R30 explained the one he had been in was tan. R30 was asked how often he got out of bed. R30 explained he thought he would get up later that day, he would like to get out of his room and meet people.Review of the clinical record revealed R30 was admitted into the facility on 1/21/26 with diagnoses that included: fracture of T7-T8 thoracic vertebra, paraplegia and generalized anxiety disorder. According to an admission nursing assessment dated [DATE], R30 was alert and orientated to person, place and time [A&O x 3].On 1/28/26 at 8:41 AM, R30 was observed lying in his bed. R30 was asked if he had gotten up the previous day. R30 explained he was told someone else was using the geri-chair, so he did not get up. But he had already asked to get up that day.On 1/28/26 at 9:15 AM, Certified Occupational Therapy Assistant [COTA] ?P' was interviewed and asked how many geri-chairs were at the facility. COTA ?P' explained there were two geri-chairs, but one of them was very small.On 1/28/26 at 11:00 AM, R30 was observed sitting in the tan geri-chair in his room. Occupational Therapist [OT] ?O', who was also present in R30 room, was asked if R30 could have used the blue geri-chair in the room. OT ?O' explained the blue geri-chair was too small for R30. When asked how wide the blue geri-chair was, OT ?O' explained it was 16 wide. OT ?O' was asked how wide the tan geri-chair was. OT ?O' explained it was 20 wide.On 1/28/26 at 11:04 AM, Certified Nursing Assistant [CNA] ?I' was interviewed and asked how many residents at the facility used geri-chairs. CNA ?I' explained they currently had three residents that sat in the geri-chair. CNA ?I' was asked if either of the other two residents would fit into the blue geri-chair. CNA ?I' explained the blue geri-chair was too small for all of their residents, they all needed the tan geri-chair.On 1/28/26 at 11:05 AM, CNA ?K' was interviewed and asked what happened when two residents wanted to get up to a geri-chair at the same time. CNA ?K' explained only one resident could get up at a time.On 1/28/26 at 12:10 PM, the Administrator, who also served as the DON, was interviewed and asked why only one resident at a time was able to get out of bed and into a geri-chair. The Administrator/DON explained she had not been informed that there were additional residents that were requesting to use a geri-chair. The Administrator/DON was asked about the small blue geri-chair with the tape and rips. The Administrator/DON explained that geri-chair should be removed and additional geri-chairs should be obtained.A facility policy on accommodation of needs was requested, none was received prior to the end of the survey.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Minimum Data Assessment (MDS) discharge assessment for one Resident (R7) of one resident reviewed for resident assessments. Findings include:Review of the recertification survey documentation software in the triggered task, Resident Assessment, revealed R7 was admitted to the facility on [DATE], and their MDS record was over [AGE] years old (had not been completed).Review of R7's resident census in the Electronic Medical Record (EMR) revealed R7 was admitted to the facility on [DATE] on a Skilled Level of Care and was discharged on 9/16/25.Review of R7's nursing Discharge summary, dated [DATE], closed on 9/18/25 by the MDS nurse, Registered Nurse (RN) C , revealed R7 was discharged from the facility on 9/16/25 with an AMA (Against Medical Advice) status, and had been admitted on [DATE] for therapy.Review of R7's MDS assessment page on 1/28/26 at 1:21 p.m., with RN C , revealed there was no MDS discharge assessment.On 1/28/26 at 1:23 p.m., RN C was asked about R7's MDS assessment and any missing assessment per the task trigger. RN C stated the discharge MDS assessment was missed and should have been completed on or near the time of R7's AMA discharge on [DATE]. RN C was asked what occurred and indicated they accidentally missed the discharge assessment, and it was not intentional.On 1/28/26 at approximately 1:45 p.m., R7's missing discharge MDS assessment was reviewed with the Nursing Home Administrator (NHA) and the Director of Nursing (DON), who was serving in dual roles. The former NHA, NHA C , was also present for the interview, as they were the administrator when the omission occurred and were serving as a survey consultant. Surveyor explained this concern was triggered by the Resident Assessment task for the recertification survey. The NHA/DON explained they were not aware of this occurrence and had no comment at that time. No additional comment or feedback was received from their team by survey exit, or at the exit conference.Review of the policy, MDS 3.0 Completion, revised 2/23/24, revealed, Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan.Policy Explanation and Compliance Guidelines: According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI [Resident Assessment Instrument - A standardized, mandatory process required by CMS (Centers for Medicare and Medicaid Services) that evaluates residents' strengths, needs and preferences to develop comprehensive individualized care plans] specified by the State.f. Discharge Assessment - Completed using the discharge date as the ARD (Assessment Reference Date - Typically marking the last day of a resident's care or services). Must be completed within 14 days of the discharge date /ARD.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an accurate, consistent description and assessment of a wound for one Resident (R15) of one resident reviewed for skin management/ wound care, per best practice standards. Findings include:On 1/26/26 at 1:28 p.m., R15 was observed seated in a high-back wheelchair outside their room. A thin gel wheelchair cushion was underneath them in their wheelchair.On 1/26/26 at 1:29 p.m., R15's bed was observed. There was a standard mattress on their bed.Review of R15's Minimum Data Set (MDS) assessment, dated 1/15/26, showed they were admitted to the facility on [DATE] with diagnoses including dementia, arteriosclerotic heart disease, and kidney disease. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 4/15, which showed R15 had cognitive impairment. The assessment revealed that R15 was incontinent of bowel and bladder. Review of R15's Care Plan (CP), accessed 1/27/26, revealed, Problem: I have a pressure ulcer: due to multiple underlying medical conditions, wounds may not heal and formation of more wounds may be unavoidable: (R15) has a Stage 2 (pressure ulcer) to left inner gluteal fold (horizontal skin crease below the buttocks); w/c (wheelchair) bound, immobility, episodes of incontinence. (R15) will refuse to lay back down during the day to elevate feet and relieve pressure to his buttocks. Category. Start date: 1/27/26. Last reviewed: 1/21/26.Review of R15's nursing progress note, by Licensed Practical Nurse (LPN) F, dated 1/21/26 at 4:50 a.m., revealed, Skin assessment completed. Writer notes an open area to left buttock (intergluteal fold). Area cleansed and treatment implemented for Calmoseptine (wound protective menthol barrier cream) applied and dry dressing BID (twice daily) and after each incontinent episode. Wound care consultation order placed.Review of R15's nursing progress noted, dated 1/27/26 at 9:59 a.m., by RN C, revealed, Observed a stage 2 to left inner buttock during toileting, has tx (treatment) order in place for Calmoseptine (ointment) and dressing; dressing needs to be discontinued as it does not adhere in this area between the buttocks; surrounding skin is macerated at this time, no measurable depth. Wound base is 100% granulation issues; incontinence and mobility; is on a w/c (wheelchair) cushion, poc (plan of care) updated; will be seen by wound care this Friday (1/30/26).Review of R15's nursing progress note, dated 1/28/26 at 5:37 a.m., by LPN F, revealed, A quarter size bed sore observed during skin assessments, writer cleansed it with NS (Normal Saline - wound care rinse) and covered with 4 x 4 Silicon foam (wound care) dressing and resident well tolerated, denies pain during the assessment. Continue to monitor. It was noted all the wound descriptions were completed by different nurses, and there were no wound measurements after the 1/21/26 progress note.Review of R15's skin assessment, dated 1/21/26, showed a new wound but had no measurements.Review of R15's skin assessment, dated 1/24/26, showed no wound description.Review of R15's skin assessment, dated 1/26/26, showed no wound description.Review of R15's nursing assessments revealed no wound description other than the initial wound description in the 1/21/26 documentation.Review of R15's EMR (electronic medical record) on 1/27/26 showed no wound consult by the wound care team, no clear description of R15's wound after 1/21/26, and no wound measurements.On 1/27/26 at approximately10:00 a.m., LPN D was asked about R15's wound to their buttocks. LPN D , reviewed the EMR and described the wound care team rounds with residents with wounds/new wounds every Friday. LPN C could not explain why R15 had not been seen by the wound care team on 1/23/26, and said they would be seen on 1/30/26, eight days later after the inception/discovery of R15's wound to their buttocks.On 1/28/26 at 10:12 a.m., the MDS nurse, Registered Nurse, RN C, was asked about R15's wound, per their progress note and CP entry on 1/28/26, as they documented the wound as a Stage 2 pressure ulcer. RN C reported they overheard nursing staff talking about R15 having a pressure ulcer on 1/27/26 and said they had observed the wound and stated the wound was a Stage 2 pressure ulcer on R15's buttocks. RN C clarified the typical process was nursing staff would have made them aware of a new (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound/pressure ulcer. RN C confirmed R15 should have been seen by the outside wound care staff on 1/23/26, who provided the wound descriptions and measurement, and they were not sure why this was missed. RN C clarified there was no wound care nurse per se in the facility, and wound care observations, measurements and descriptions were provided by the wound care team who made rounds every Friday. RN C stated they put a note up at the nurse's station to remind staff R15 needed to be seen on 1/30/26, when the wound care staff next rounded in the building. RN C was asked if their expectation would have been there would be wound measurements for a documented pressure ulcer, so 1/30/26's measurements could have been compared to 1/21/26's measurements, per best standards of wound care practice. RN C said they needed to review the skin and wound policy. Review of R15's Electronic Medical Record (EMR) with RN C revealed on 1/28/26 LPN F had classified the wound as the size of a quarter in their progress note. When asked if an LPN F could stage or measure a wound, RN C clarified an LPN could not stage a wound, however, they could have completed measurements or sent for an RN in the building including themselves to have measured R15's wound. RN C concurred there were no wound measurements in the EMR for R15.On 1/28/26 at approximately 10:20 a.m., RN C reported the wound description, and measurements should have been documented in the EMR. RN C acknowledged they should have completed this documentation in the wound management section of the chart when they described R15's wound which they called a Stage 2 pressure ulcer on 1/27/26, when they had observed the wound. RN C reported they measured R15's wound however had forgotten to place the measurements in R15's chart. RN C was asked if the wound being described as quarter size was acceptable per standards of best practice for wound care. RN C said they would need to review the wound care policy. RN C agreed best practices for wound care indicated any new pressure ulcer and or skin wound should be measured at the wound inception. RN C reported they understood the concern without an initial measurement the wound care team wound not be able to tell if the wound progressed when they were scheduled to round the facility's' residents' wounds on 1/30/26.Review of the facility's skin and wound care policies with RN C on 1/28/26 at 10:23 a.m., received from the Nursing Home Administrator (NHA) and Director of Nursing (DON), who assumed both roles, revealed the policies referenced the size of the wound(s) should be noted, with no further description.Review of R15's physician orders on 1/28/26 with RN C revealed orders for Calmoseptine (ointment) wound care treatment to R15's buttocks wound remained in place.Review of R15's EMR with RN C revealed their Braden assessment score was 16, which per RN C showed they were at risk for pressure ulcers/skin concerns. RN C reported R15's Stage 2 pressure ulcer was unavoidable, which they documented in R15's Care Plan.On 1/28/26 at 10:56 a.m., the former NHA, NHA B was asked who oversaw wound care currently and when they were the NHA. NHA B reported the DON oversaw wound care oversight.On 1/28/26 at 11:12 a.m., Observation of R15's wound care by Surveyor RN, with LPN E and CNA K, revealed an area on the left gluteal fold that appeared to be Moisture Associated Skin Damage (MASD), approximately 1 1/4 inch by 3/4 inch. The Calmoseptine cream applied covered the entire area completely. On 1/28/26 at 1:05 p.m., LPN E was asked about R15's wound description during their wound care treatment on this date, when observed by RN Surveyor. LPN E reported R15's wound appeared to be more so a skin tear from what my eyes saw, but I don't stage (stage the wounds).It was there in the gluteal fold.We don't measure it. Our wound care lady (wound care provider staff) does this on Fridays. It was noted the RN Surveyor described the appearance during the wound observation as MASD (MASD - non- pressure related). Both LPN E and the RN surveyor concurred the wound did not appear to be a pressure ulcer, showing marked documentation inconsistencies since R15's wound to their left buttocks gluteal fold was first described by nursing staff on 1/21/26, and described on 1/28/26 by LPN F, in their nursing progress note. On 1/28/26 at approximately 1:45 p.m., the NHA/DON was asked about R15's and the documentation inconsistencies and documentation omissions by nursing facility staff, no wound measurements, as well as R15 not being seen by the wound care provider team on 1/23/26, per best practice standards for wound care. The NHA/DON reported they had observed R15's wound on this (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor Nursing and Rehabilitation Center LL	50 N Perry St, 1st Floor Pontiac, MI 48342

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date (1/28/26), and clarified the wound was MASD, not a pressure ulcer. The NHA/DON reported the wound care treatment was appropriate (Calmoseptine) and remained in place. The NHA/DON confirmed they would have their wound care provider observe R15's buttocks wound on 1/30/26. The NHA/DON reported they understood the concerns related to wound care best practices, per facility policy, and would move forward with staff education.Review of the facility policy, Wound Treatment Management, DateImplemented: 11/1/2022.Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.Policy Explanation and Compliance Guidelines:1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.b. Characteristics of the wound:i. Pressure injury stage (or level of tissue destruction if not a pressure injury).ii. Size - including shape, depth, and presence of tunneling and/or undermining.iii. Volume and characteristics of exudate.iv. Presence of pain.v. Presence of infection or need to address bacterial bioburden.vi. Condition of the tissue in the wound bed.vii. Condition of peri-wound skin.c. Location of the wound.d. Goals and preferences of the resident/representative.6. Guidelines for dressing selection may be utilized in obtaining physician orders (see attached).a. The guidelines are to be used to assist in treatment decision making.b. Due to unique needs and situations of individuals, the guidelines may not be appropriate foruse in all circumstances.c. The facility will follow specific physician orders for providing wound. 7. Treatments will be documented on the Treatment Administration Record.8. The effectiveness of treatments will be monitored through ongoing assessment of the wound.Considerations for needed modifications include:a. Lack of progression towards healing.b. Changes in the characteristics of the wound (see above).c. Changes in the resident's goals and preferences, such as at end-of-life or in accordance withhis/her rights.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure wound care was implemented per physician orders, as evidence by missed and incomplete wound care treatments for one(R2) of three residents reviewed for wound care. Placing the resident at risk for infection, delayed wound healing and further skin break down. Findings include: On 1/26/26 at 9:30 AM, R2 was observed lying in the bed with a green wedge placed under their left side. R2, was then interviewed about their stay at the facility but the conversation was not coherent due the resident having a Brief interview for mental status(BIMs) score of 7 which indicated severe cognitive impairment. A review of the record revealed that, R2 was admitted to the facility on [DATE] with the admitting diagnosis of metabolic encephalopathy, Pressure Ulcer of the sacral region, unstageable and muscle weakness. A further review of the record revealed that on 1/16/26, R2 was seen by wound care, the consult report stated, Resident has two new wounds on her mid lower back that is a UTD (unable to determine) and a new right heel stage two. Both heels were hyper granulating, sliver nitrate used to knock it down. See orders for details and please off load. Wound was consulted and wound care was ordered in part . Left lower back un staged pressure 3 times a week and as needed Normal saline or wound cleanser Calcium alginate with Medi honey border foam The record revealed that, on 1/28/26 the wound care orders that had been provided by the wound care provider on 1/16/26 was not carried out in the medical record. On 1/28/26 at 10:27 AM, the Director of Nursing (DON) was interviewed, and they were asked who over sees the wounds at the facility and who is responsible for completing and transcribing treatments. The DON reported that there was an outside company that oversees the care and physician oversite for the wounds at the facility. The DON reported that floor nurses was responsible to round with the provider and if there were any new orders or changes made to existing orders the floor nurses are to carry the orders out. The DON, was asked about R2's wounds and how often were they seen. The DON reported, that R2 was seen monthly and it was up to the facility to ensure treatments and skin checks were completed accurately. The DON was then asked about the wound care consult on 1/16/26 and where could the orders be found and the documentation of the implementation of the Silver Nittrate order. The DON was also asked, how are they monitored the status of R2 wounds if there is not any documentation for two new skin areas that deteriorated. The DON, reported that, they will be overseeing the coordination of care for wounds moving forward. There was no additional information provided by exit.

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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** Based on observation, interview, and record review, the facility failed to ensure one Resident (R15) of one resident reviewed for accidents/falls had their fall interventions implemented after two falls out of bed. Findings include:On 1/26/26 at 1:28 p.m., R15 was observed seated in a high-back wheelchair outside their room. R15 was seated on a thin gel wheelchair cushion in their wheelchair.Review of R15's Minimum Data Set (MDS) assessment, dated 1/15/26, showed they were admitted to the facility on [DATE]. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 4/15, which showed R15 had cognitive impairment. Review of R15's profile revealed they had diagnoses including metabolic encephalopathy (brain dysfunction from metabolic causes), dementia, heart disease, kidney disease, a fall with a fractured clavicle, and a history of bilateral (both) hip replacements.Review of R15's Fall Care Plan, accessed 1/27/26, dated 1/10/26, revealed, Problem: I am at risk for falling r/t (related to): Mobility limits, Cognitive limits, hx (history of) falls, impulsive attempts to self transfer; has dx (diagnosis) of dementia and will not remember to use a call light for assistance .Review of R15's Fall Care Plan Interventions, dated 1/27/26, showed interventions including ensuring their bed was in the lowest position and their call light being in reach at all times.On 1/27/26 at 2:55 p.m., R15 was observed in their hospital bed. R15 had the covers over them. R15's bed was mid-height (transfer height). It was not in the low position.On 1/27/26 at 9:29 a.m., R15 was observed in their hospital bed sleeping. R15's bed was observed at mid-height, and their soft touch pad call light was on their nightstand, out of their reach. Their bed was a regular flat mattress, with a bare floor. It was noted R15's bed was the same height as their roommates bed, who self transferred, when viewed from the foot of their beds.On 1/27/26 at approximately 9:32 a.m., Licensed Practical Nurse (LPN) H and Certified Nurse Aide (CNA I) were asked to observe R15 in their bed with Surveyor present. LPN H and CNA I observed R15 and confirmed R15's bed was at mid-height, and their call light was out of reach, on their nightstand.On 1/28/26 at approximately 9:35 a.m., LPN H was asked about the observation. LPN H confirmed R15 was at risk for falls and understood the concern.On 1/28/26 at 9:40 a.m., CNA I was asked about R15's bed being at mid-height and their call light being out of reach, per their fall Care Planned interventions. CNA I reported they were assisting with the residents on the unit, and had removed R15's call light when they were picking up their tray and cleaning their tray table and forgot to put R15's call light back in their reach. CNA I also stated they were not aware R15's bed was supposed to be at the lowest height. CNA I said on this date (1/28/26) there was no one present to give them shift report at shift change. CNA I explained they were made aware R15 had fallen a few days ago, and said they should have lowered their bed. CNA I was asked if they had reviewed R15's Care Plan interventions. CNA I said they were a newer employee and they had not been given access to any residents' Care Plans, including R15's. CNA I reported they had worked as a CNA elsewhere prior to this facility, and they knew they needed to have access to residents' Care Plans.On 1/28/26 at approximately 10:30 a.m., R15 was observed sleeping in their bed with their bed was lowered and call light in reach. R15's bed was observed a few inches lower than their roommates bed, when viewed from the foot of bed.Review of R15's nursing progress notes revealed R15 had three falls since their admission on [DATE], as follows:1/10/26. Fall out of chair. Non injury.1/23/26. Fall out of bed. No injury.1/25/26. Fall out of bed. Skin tear left elbow.Review of R15's Fall event reports related to their three falls revealed their Care Plan was updated with new interventions on 1/10/26, however was not marked as reviewed or updated on 1/23/26 and 1/25/26.Further review of R15's Fall Care Plan revealed there were no new fall interventions after their falls, until the Care Plan was updated on 1/27/26, two days after their second fall out of bed.On 01/28/2026 at 11:49 a.m., the Nursing Home Administrator (NHA)/ Director of Nursing (DON) (who assumed both roles this month) was asked about R15's Fall Care Plan (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions not being followed per their Care Plan or reviewed shortly after their falls out of bed. The NHA was also made aware of CNA I reporting they did not have Care Plan access. The NHA/DON reviewed R15's Care Plan and indicated they understood the training and implementation/review concerns and planned to follow up.Review of the policy, Incidents and Accidents, dated 11/01/22, revealed, It is the policy of this facility for staff to utilize Incident Reports to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident.Policy Explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences.Review of the policy, Comprehensive Care Plans, revised 2/26/25, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care.8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain physician orders for care and monitoring of a peripherally inserted central catheter [PICC] for one (R19) of one resident reviewed for PICC lines. Findings include:On 1/26/26 at 8:56 AM, R19 was observed walking from his bathroom to his bed. An intravenous [IV] pole with an IV bag and tubing was observed next to the bed. R19 was asked if he was receiving IV medication while at the facility. R19 explained he was receiving antibiotics through is PICC line. R19 was asked how often the facility changed the dressing on his PICC line. R19 explained he was not sure if they had changed the dressing. Observation of the PICC line dressing on R19's right upper arm revealed a dressing held on with tape at the top and bottom and faintly dated either 1/12/26 or 1/22/26.Review of the clinical record revealed R19 was admitted into the facility on 1/9/26 and readmitted [DATE] with diagnoses that included: osteomyelitis of vertebra, heart disease and osteoporosis. According to the Minimum Data Set [MDS] assessment dated [DATE], R19 was cognitively intact.Review of physician orders for R19 revealed no order found for dressing changes and no order found for monitoring of PICC line site for signs and symptoms of infection.On 1/27/26 at 11:45 AM, the Administrator, who also served and the Director of Nursing [DON] was interviewed and asked how often a PICC line dressing should be changed. The Admin/DON explained the dressing should be changed every week or if soiled. The Admin/DON was asked about R19's PICC line dated either 1/12/26 or 1/22/26. The Admin/DON explained R19 had gone to the hospital to have the PICC line replaced on 1/22/26 and was not due for a dressing change yet. The Admin/DON was asked about the lack of physician orders for dressing change and monitoring of the site. The Admin/DON looked at the current and discontinued orders for R19 and did not find any physician orders regarding the PICC line. The Admin/DON was asked how the staff would know when to change the dressing, or where they would document that it was done. The Admin/DON had no answer.Review of a facility policy titled PICC/Midline/CVAD Dressing Change dated 11/1/22 read in part, .It is the policy of this facility to change peripherally inserted central catheter (PICC), midline or central venous access device (CVAD) dressing, weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify typre of dressing and frequency of changes.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to provide administration of the Influenza vaccine for one (R6) of five residents reviewed for immunizations. Findings include:Review of the clinical record revealed R6 was admitted into the facility on [DATE] with diagnoses that included: stroke, heart failure and diabetes.Review of R6's Preventive Health Care tab revealed on 12/23/25 documentation of R6 having received Pneumococcal, RSV [respiratory syncytial virus] and COVID-19 vaccines previous to admission to the facility. There was no documentation of the Influenza vaccine.On 1/27/26 at 3:21 PM, the Administrator, who was also serving as the Director of Nursing [DON] and Infection Preventionist, was asked to provide documentation of R6's consent or declination form for the Influenza vaccine.Review of a Resident - Vaccine Consent form, signed by R6 and dated 12/23/25 revealed a check mark in the Accept circle for the FLU Vaccine.On 1/27/26 at 4:05 PM, R6 was observed sitting in a wheelchair in her room. R6 was asked if she had received the Influenza vaccine while at the facility. R6 explained she had signed up for it, but had not received it yet.Review of a facility policy titled, Influenza Vaccination dated 11/1/22 read in part, .Influenza vaccinations will be routinely offered annually from October 1st through March 31st. Individuals receiving the influenza vaccine, or their legal representative, will e required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record.