| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235722 | A. Building<br>B. Wing | 04/01/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mission Point Nursing & Physical Rehabilitation Ce | 313 Sherwood Street<br>Holly, MI 48442 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>This citation pertains to intake 2966880.Based on observation, interview and record review, the facility failed to maintain clean, comfortable, homelike environment for multiple residents that reside in the facility, including those on the A, B and D units. Findings include:On 3/30/2026 at 10:17 AM observed bagged soiled linens overflowing from vendor provided storage containers and being stored on the floor and a strong odor of urine present. During this observation when queried, Housekeeping/Maintenance Director (Staff 'W') said the laundry service pick up days are Monday, Wednesday, and Friday around 11:00 AM, so Monday is the heaviest collection day. Staff 'W' indicated that they could check if another collection bin is available.<br><br>On 3/30/2026 at 10:18 AM interviewed Staff 'W' about the strong odor of urine near the building entrance. Staff 'W' said it is a recurring issue with some residents urinating in this area during the night time and that housekeeping staff provide daily cleaning of those areas of the carpeting once they arrive in the morning.<br><br>Review of a complaint reported to the State Agency included an allegation of .The entire unit smells like rotting bodies and urine .<br><br>On 3/30/26 at 8:30 AM, upon entry into the facility, a strong urine odor was immediately identified in the front lobby area. There were two ceiling air units that had vent grids that were heavily soiled with stringy, dust debris. Throughout the survey, urine odors remained prevalent throughout the front lobby, and the hallways on A, B, and D units.<br><br>On 4/1/26 at 10:05 AM, an interview was conducted by the Housekeeping/Maintenance Director (Staff 'W'). When asked if they completed any monitoring of the ceiling ventilation systems, Staff 'W' reported they didn't do that. They reported the ventilation systems from the front lobby and hallways were split systems. When asked about the soiled ceiling vent grids, Staff 'W' confirmed the same and reported housekeeping should have cleaned them. When asked about the strong urine odors, Staff 'W' reported the same concerns and reported there was a resident that had behaviors with urination, and their room was nearby the front lobby. Throughout the survey, the room occupied by this resident was not observed with any urine odors.<br><br>Additional observations of the A/B nursing station, and D nursing station revealed heavily soiled ceiling vent air units. Staff 'W' acknowledged the soiled status and reported they would need to be cleaned immediately. When asked if that was part of the housekeeping staff's daily rounds, Staff 'W' reported those should be included, including if they were visibly soiled and reported some were missed. Staff 'W' was asked about the internal washable filters that were heavily soiled with dust debris, and they reported their contracted heating and cooling company must've missed a couple.<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | According to the facility's policy titled, Exhaust Fan Inspection dated 1/11/2021:<br><br>.All resident and non-resident areas have exhaust vents/fan/s. Each area needs to be verified that the vent covers are dust/dirt free and that the vent can be confirmed to function by holding up a piece of multi-fold paper.All vent covers should be cleaned inside and out. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2607613, 2658268, 2666429, 2793060.Based on interview and record review, the facility failed to protect the residents' right to be free from verbal abuse by a staff, verbal abuse by a resident, physical abuse by a resident, and failed to protect the resident's right to be free from neglect for five (R1, R30, R53, R64 and R76) of six residents reviewed for abuse and neglect. Findings include:<br><br>According to the facility's policy titled, Abuse, Neglect and Exploitation dated 9/2025:<br><br>.Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse.physical abuse.'Verbal Abuse' means the use or oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking.'Neglect' means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.<br><br>R1<br><br>Review of a facility reported incident (FRI) submitted to the State Agency on 11/28/25 documented, in part:<br><br>.On November 27, 2025 at around 5.30pm, (R1) asked (Staff 'A') Dietary Aide for a cup of coffee. (Staff 'A') stated that she could not provide him with a cup of coffee at this time. (R1) stated, F*** You. to (Staff 'A') and (Staff 'A') stated back to (R1), FU and walked away from the resident.Investigation Summary.On November 27, 2025 it was witnessed by (Nurse 'F'), (R1) asked (Staff 'A'), Kitchen Aide, for a cup of coffee. (Staff 'A') replied that I can not give you any coffee. (R1) then called (Staff 'A') a Bitch. (R1) replied F*** You. (Staff 'A') replied F U you back. This incident was documented as inconclusive in regard to abuse, despite the witnessed incident.<br><br>Review of clinical record revealed R1 was admitted into the facility on 2/2/23 and readmitted on [DATE] with diagnoses that included: bipolar disorder current episode depressed, severe, with psychotic features, mild neurocognitive disorder due to known physiological condition without behavioral disturbance, Parkinson's disease without dyskinesia without mention of fluctuations, mild cognitive impairment of uncertain or unknown etiology, schizoaffective disorder bipolar type, chronic pain syndrome, and Post-Traumatic Stress Disorder.<br><br>According to the quarterly Minimum Data Set (MDS) assessment 2/17/26, R1 had intact cognition and had feelings of being down, depressed, or hopeless 7-11 days (half or more of the days), feeling tired or having little energy for 12-14 days (nearly every day), feeling bad about self - or that you are a failure or have let self or your family down (12-14 days (nearly every day), trouble concentrating on things, such as reading the newspaper or watching television (12-14 days - nearly every day).<br><br>On 3/31/26 at 1:12 PM, an interview was conducted with R1. When asked about the incident of verbal abuse with Staff 'A' from 11/27/25, R1 reported they didn't think staff should've said that and hadn't (continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | seen them since. R1 further reported they were really upset that another resident called them a [NAME] and said they were acting like a little girl during bingo last week.<br><br>On 3/31/26 11:15 AM, an interview was conducted with the Administrator who also reported they were the facility's Abuse Coordinator. When asked about the abuse incident on 11/27/25 between R1 and Staff 'A' and why they had documented inconclusive in the portal to the State Agency, the Administrator confirmed they had substantiated verbal abuse occurred and that should've been documented as substantiated.<br><br>During review of R1's clinical record, an additional abuse incident was identified.<br><br>Review of the progress notes included an entry on 3/27/26 at 12:57 PM by Social Worker (SW 'G') that documented, in part:<br><br>(R1) spoke with me today to tell me that he is upset about bingo.He was upset also because he said that another resident had called him a '[NAME]' and he did not like the comment being related to sexual orientation.<br><br>On 3/30/26 at 3:46 PM, the Administrator was asked about R1's concerns documented by SW 'G'. They reported that had not been reported to the state agency.<br><br>On 3/30/26 at 3:52 PM, the Administrator was asked to clarify if that resident-to-resident incident should've been reported and they stated it wasn't reported because It was verbal and he started it. Basically, he called someone a name and (R53) called him a [NAME]. (R53) said he didn't call him that and said for him to stop.<br><br>Review of the facility's documentation of the resident-to-resident incident from 3/27/26 further identified the incident occurred between R1, R30, and R53. Documentation included:<br><br>(R1) has been living at (facility name) since February 10, 2023. (R1) is 63 year of age and has a BIMS (Brief Interview for Mental Status) Score of 15 (which indicated intact cognition). Diagnoses include Bipolar disorder, Neurocognitive Disorder, Schizoaffective Disorder and Generalized Anxiety Disorder.<br><br>(R53) has been living at (facility name) since January 9, 2024. (R53) is [AGE] years of age and has a BIMS Score of 15. Diagnoses include Mild Cognitive Impairment, Major Depressive Disorder, Other Psychoactive Substance Abuse and Bipolar disorder.<br><br>(R30) has been living at (facility name) since January 25, 2025. (R30) is [AGE] years of age and has a BIMS Score of 3 (severe cognitive impairment). Diagnoses include Vascular Dementia, Generalized Anxiety Disorder, Major Depressive Disorder and Diabetes Mellitus.<br><br>(R1) stated that (R53) called him a [NAME].<br><br>(R53) was interviewed by Social work (SW 'G') and he stated that he did not call (R1) a [NAME] but did call him a fat punk as he acts like a little girl.<br><br>(R53) stated that during bingo (R1) was calling (R30) names, Asshole and bitch and stated that it was because the bingo screen was in front of (R30) and that (R1) was upset as that is why (R30) has all the bingo bucks.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | (R1) stated that he was upset about what happened at Bingo on Monday. (R1) stated, (Name of Activity Aide/Staff 'B') put the screen that gives the bingo numbers right in front of (R30's) face.<br><br>(R1) stated, Its not fair as she has a stack of over $100 bingo dollars. (R1) stated, I don't care if she is retarded or not its not fair that I only have 4.<br><br>(R1) said, Everyone in the room was raising hell at me because they were afraid of not getting bingo bucks. (R53) another resident was worried about his Bingo Bucks and he called me a [NAME] to get even with me.<br><br>(R1) stated that (R53) said stop acting like a little girl>' <sic><br><br>(R1) stated, I want to be treated fairly in Bingo. (Staff 'B') is not honest as he puts the screen in front of (R30).<br><br>On 3/31/26 at 10:54 AM, further discussion was conducted with the Administrator regarding their documentation of the resident-to-resident incident from 3/27/26. When asked about their documentation above, which included derogatory/disparaging remarks and how that had not been identified as instances of verbal abuse, the Administrator acknowledged they should have.<br><br>R76<br><br>On 4/1/226 at 10:39 AM, a review of a facility reported incident investigation file completed by the facility's Administrator/Abuse Coordinator was reviewed. The investigation file contained a summary that read, .(R76) has a BIMS (Brief Interview for Mental Status) score of 15 (indicating intact cognition). Diagnoses are Malignant Neoplasm of Bilateral Ovaries, Malignant Neoplasm of Abdomen, Bipolar disorder and Depression. On October 23, 2025, on rounds (R76) reported to the Administrator at around 8:30am [sic] that she has [sic] pushed her call light asking for pain medication and the Nurse did not respond timely .(Social Worker 'G') interviewed (R76) and (R76) Stated: [sic] I woke up during the night and I was in pain. I put my call light on for pain medication. The nurse came into my room and I told her that I wanted pain medication. The Nurse turned off my call light and left the room About 90 minutes later the Nurse had not returned with my pain medication so I put my light on again. The Nurse came back in the room and left again without giving pain medication and I had to wait for another hour before the Nurse returned with my pain medication .CONCLUSION 1. The Nurse has been counselled to ensure that when a resident requests pain medication to administer the pain medication as ordered by the Doctor timely .<br><br>Continued review of the file revealed a Facility Reported Incident (FRI) electronically submitted to the State Agency that alleged Nurse 'U' neglected R76. The file further contained past non-compliance documents, however; the past non-compliance was not accepted as the facility was out of compliance at the time of the survey.<br><br>On 4/1/26 at 11:06 AM, an interview was conducted with the facility's Administrator/Abuse Coordinator regarding the investigation. The Administrator was asked how they determined to submit a FRI for Nurse 'U' neglecting R76 and said, I felt like it was neglect, further adding R76 needed their narcotic pain medication on a regular basis due their end-of-life Hospice Status and aggressive cancer diagnoses. They were asked if they interviewed Nurse 'U' and said they did. When asked what Nurse 'U' reported to them, the Administrator said they did not remember and added, I don't think she (Nurse 'U') understood why R76 needed her hourly pain medications.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Administrator was then asked if Nurse 'U' was still employed at the facility and reported Nurse 'U' quit without notice after leaving her shift on the morning of 10/23/25.<br><br>R64 and R30<br><br>A review of a FRI reported to the State Agency revealed an allegation that R30 tapped R64 on the bottom and R64 hit R30 on her face.<br><br>On 3/30/26 at 11:10 AM, R30 was interviewed. When asked about the altercation with R64, R30 did not remember the incident.<br><br>On 3/30/26 at 11:59 AM, R64 was interviewed. When asked about the altercation with R30, R64 mumbled and said something about being a pimp. R64 did not give a sensical answer.<br><br>A review of an investigation conducted by the facility revealed the following:<br><br>A typed summary (undated and unsigned) that noted, .On October 28, 2025, (R30) went up to (R64) and yelled at (R64) and hi [sic] him on his buttocks. (R64) turned around and hit (R30) on her right chin .(R30) stated, 'I was in the game room. It was a bad thing, that guy is good to me from way back in the day. Yesterday he hit me in the face. I can't remember if I did anything .(R64) stated, 'I was throwing something away in the garbage can and I got punch on my [NAME] by a 'Transgender'. The crowd joined in they wanted me to accept the assault. I punched him back . The summary did not include any conclusion to the investigation. A review of the investigation submitted to the State Agency revealed abuse was Unsubstantiated.<br><br>A handwritten statement (undated) by Activity Staff 'E' noted, On Tuesday October 28th 2025, (R30) came into the dining room while (Staff name) and I were doing our craft activitie [sic]. (R30) stated (R64) had just struck her in the forehead. I immediately went to go speak with (R64) to see his side of the story. (R64) stated (R30) had struck him in the [NAME] end so he turn around and hit her in the forehead .(R64) then came in to the dining room after all has settled down and incident had been reported yelling at (R30) stating very mean and inappropriate things .<br><br>A typed statement dated 10/29/25 from an unknown person noted, .Met with (R64) today in follow up after an incident yesterday with another resident. I asked him if he could tell me what happened yesterday. He stated that he was throwing something way in the garbage can and 'I got punched on my [NAME] by a transgender'. He went on to say 'the crowd joined in, they wanted me to accept the assault'. I asked him what he did and he stated, 'I punched him' .<br><br>A review of R64's clinical record revealed R64 was admitted into the facility on 6/14/24 and readmitted on [DATE] with diagnoses that included: schizoaffective disorder, bipolar type, and dementia. A review of a MDS assessment dated [DATE] revealed R64 had intact cognition and no behaviors.<br><br>A review of an Incident Note for R64, dated 10/28/25 revealed, It was reported to writer that resident had an incident with another resident (R30) in activity room. resident interviewed and stated 'I was standing up throwing some papers away in the garbage can and she came up behind me and punched me right in my [NAME], so I turned around and punched her back.'<br><br>A review of R30's clinical record revealed R30 was admitted into the facility on 1/25/24 and<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | readmitted on [DATE] with diagnoses that included vascular dementia with behavioral disturbance. A review of a MDS assessment dated [DATE] revealed R30 had severely impaired cognition.<br><br>A review of a Nursing Progress Note for R30 dated 10/28/25 revealed, (R30) went up to (R64) in the hall. She yelled what are you doing. She hit (R64) in the buttocks. (R64) turned around and hit patient in right chin area with closed fist. She stated she yelled, 'What are you doing sir?' She stated, 'He punched in the face.'<br><br>On 3/31/26 at 11:33 AM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. When queried about how she determined abuse was not substantiated, the Administrator reported she read the resident's statements. When queried about R64 admitting to punching R30 in the face and whether that would be considered physical abuse, the Administrator reported it was. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report witnessed resident to resident verbal abuse and an injury of unknown origin to the State Agency for four (R1, R30, R53, and R80) of six residents reviewed for abuse and neglect. Findings include:<br><br>R1, R30, R53<br><br>During an investigation of a separate verbal abuse incident between a staff member and R1, the following additional verbal abuse concerns were identified:<br><br>An entry in R1's clinical record included a progress note dated [DATE] at 12:57 PM by Social Worker (SW 'G') documented, in part:<br><br>(R1) spoke with me today to tell me that he is upset about bingo.He was upset also because he said that another resident had called him a '[NAME]' and he did not like the comment being related to sexual orientation.<br><br>On [DATE] at 3:46 PM, the Administrator was asked about R1's concerns documented by SW 'G' and whether that had been reported to the State Agency. The Administrator reported that had not.<br><br>On [DATE] at 3:52 PM, the Administrator was asked to clarify if that resident-to-resident incident should've been reported and they stated it wasn't reported because It was verbal and he started it. Basically, he called someone a name and (R53) called him a [NAME]. (R53) said he didn't call him that and said for him to stop.<br><br>Review of the facility's documentation of the resident-to-resident incident from [DATE] further identified the incident occurred between R1, R30, and R53. Documentation included:<br><br>(R1) has been living at (facility name) since February 10, 2023. (R1) is 63 year of age and has a BIMS (Brief Interview for Mental Status) Score of 15 (which indicated intact cognition). Diagnoses include Bipolar disorder, Neurocognitive Disorder, Schizoaffective Disorder and Generalized Anxiety Disorder.<br><br>(R53) has been living at (facility name) since [DATE]. (R53) is [AGE] years of age and has a BIMS Score of 15. Diagnoses include Mild Cognitive Impairment, Major Depressive Disorder, Other Psychoactive Substance Abuse and Bipolar disorder.<br><br>(R30) has been living at (facility name) since [DATE]. (R30) is [AGE] years of age and has a BIMS Score of 3 (severe cognitive impairment). Diagnoses include Vascular Dementia, Generalized Anxiety Disorder, Major Depressive Disorder and Diabetes Mellitus.<br><br>(R1) stated that (R53) called him a [NAME].<br><br>(R53) was interviewed by Social work (SW 'G') and he stated that he did not call (R1) a [NAME] but did call him a fat punk as he acts like a little girl.<br><br>(R53) stated that during bingo (R1) was calling (R30) names, Asshole and bitch and stated that it was (continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | because the bingo screen was in front of (R30) and that (R1) was upset as that is why (R30) has all the bingo bucks.<br><br>(R1) stated that he was upset about what happened at Bingo on Monday. (R1) stated, (Name of Activity Aide/Staff 'B') put the screen that gives the bingo numbers right in front of (R30's) face.<br><br>(R1) stated, Its not fair as she has a stack of over $100 bingo dollars. (R1) stated, I don't care if she is retarded or not its not fair that I only have 4.<br><br>(R1) said, Everyone in the room was raising hell at me because they were afraid of not getting bingo bucks. (R53) another resident was worried about his Bingo Bucks and he called me a [NAME] to get even with me.<br><br>(R1) stated that (R53) said stop acting like a little girl>' <sic><br><br>(R1) stated, I want to be treated fairly in Bingo. (Staff 'B') is not honest as he puts the screen in front of (R30).<br><br>On [DATE] at 10:21 AM, a phone interview was completed with Staff 'B'. When asked to recall the events from the resident-to-resident altercation with R1, R30 and R53, Staff 'B' reported they were playing bingo and R1 was freaking out because R30 had to be by them and they had the bingo tablet. Staff 'B' reported R1 started going off and another resident (R53) stepped in and said he needed to stop or leave and then R1 went full blown at him. Staff 'B' reported R1 said he couldn't see the table and was being rude to (R30). When asked what they meant by being rude Staff 'B' reported they couldn't recall specific details. When asked if they reported that to anyone, Staff 'B' reported they did report it to a few CNAs (Certified Nursing Assistants) and the nurses and then after the shift, they reported it to their boss and that was it. When asked if they continued the bingo activity, Staff 'B' reported they did and also reported R1 got angry and left and did return but stayed silent. When asked if anyone from Administration had requested they write a statement of the events that occurred, Staff 'B' reported they had been asked on Monday and they verbally told them what happened. When asked who they talked to, Staff 'B' reported their boss (Activity Director/Staff 'V').<br><br>On [DATE] at 10:44 AM, an interview was conducted with the Staff 'V'. When asked what they could recall regarding the verbal abuse incident between R1, R30 and R53, Staff 'V' reported Staff 'B' had called them to explain (R1) was upset. They further reported they were not in the facility. Upon review of their cell phone, Staff 'V' reported Staff 'B' had called them on [DATE] at 5:59 PM. When asked what had been reported to them, Staff 'V' reported just that R1 had a verbal issue that he was upset and left. Staff 'V' further reported Staff 'B' never reported any derogatory statements but should've notified the abuse coordinator which was (Name of Administrator). When we had discussion it was investigated and that's when the other things came to light (with R30 and R53).<br><br>On [DATE] at 10:54 AM, further discussion was conducted with the Administrator regarding their documentation of the resident-to-resident incident from [DATE]. When asked about their documentation which included derogatory/disparaging remarks and why those had not been identified that as instances of verbal abuse, the Administrator acknowledged they should have and was unable to offer any further explanation.<br><br>When asked when they were first notified of the allegations of verbal abuse, the Administrator reported they were notified on a concern form from a Nurse on Monday ([DATE]). The Administrator (continued on next page) |

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| | 235722 | A. Building<br>B. Wing | 04/01/2026 |

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| Mission Point Nursing & Physical Rehabilitation Ce | 313 Sherwood Street<br>Holly, MI 48442 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | reported the concern form was dated [DATE] and acknowledged that date did not make sense and further reported they should've been notified of the actual incidents.<br><br>When asked why this hadn't been reported as an instance of resident-to-resident verbal abuse once they completed their investigation, the Administrator reported they should have. When asked if Staff 'B' should've notified them of what they witnessed, the Administrator reported they should have been notified immediately.<br><br>A review of a facility policy titled, Abuse, Neglect and Exploitation revised on 9/2025, revealed, in part, the following, .The facility will implement the following .Reporting of all alleged violations for the Administrator, state agency, adult protective services and to all other required agencies .within specified timeframes .Immediately, but not later than 2 hours after the allegation is made, if the vents that cause the allegation involve abuse or result in serious bodily injury .<br><br>R80<br><br>A review of R80's clinical record revealed R80 was admitted into the facility on [DATE], readmitted on [DATE], and expired in the facility on [DATE]. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R80 had moderately impaired cognition, one-sided impairment of the upper and lower extremities, was dependent on staff for toileting hygiene, rolling left and right, transferring, and going from sitting to lying. R80 did not stand or walk and had no history of falls.<br><br>A review of R80's progress notes revealed the following:<br><br>On [DATE] at 3:38 AM, Registered Nurse (RN) 'H' documented the following in a Nursing Progress Note, Resident last seen alive between 01:30 (AM) and 01:45 (AM) at which time he was repositioned, changed. At 02:08 (AM) nurse called to the room as resident observed out of bed. Nurse observed resident between bed and window with his shoulders off the floor, head stuck between bed and wardrobe face down. Unable to free resident's head until bed moved. Resident had no pulse, no respirations, No heart sounds on auscultation. Pronounced deceased at 02:13 (AM) by the nurse, RN. 911 called, administrator, DON (Director of Nursing), unit managers notified by phone .<br><br>On [DATE] at 3:16 AM, Unit Manager, Licensed Practical Nurse (LPN), 'I' documented the same as the above progress note in a Nursing Progress Note.<br><br>On [DATE] at 11:18 AM, the Administrator and DON were asked to provide any incident reports and investigations for R80 for the month of February 2026.<br><br>A review of an incident report provided by the facility revealed on [DATE] at 2:08 AM, Resident last seen alive between 01:30 (AM) and 01:45 (AM) at which time he was repositioned, changed. At 02:08 (AM) nurse called to the room as resident observed out of bed. Nurse observed resident between bed and window with his shoulders off the floor, head stuck between bed and wardrobe face down. Unable to free resident's head until bed moved. Resident had no pulse, no respirations, No heart sounds on auscultation. Pronounced deceased at 02:13 (AM) by the nurse, RN . No documented investigation was provided with the incident report.<br><br>On [DATE] at 3:55 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. When queried about whether she was notified about R80's death and how he was found, the Administrator reported the nurse (RN 'H') called her and said R80 was found on the (continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | floor with his head stuck between the bed and the dresser and that he was deceased . When queried about how that happened, the Administrator reported she did not know. The Administrator said she did not report the incident to the State Agency and did not offer a reason why.<br><br>On [DATE] at 8:05 AM, an interview was conducted with RN 'H', who was the nurse assigned to R80 on the night shift of [DATE]-[DATE]. When queried about what happened with R80 on [DATE], RN 'H' reported she was called to the room by two Certified Nursing Assistants (CNAs), one of them being CNA 'J'. They told her R80 was out of bed. When RN 'H' entered the room, R80 was observed with his head face down stuck between the armoire and the bed frame with his feet forcefully wedged underneath the metal base of the over bed table that was beside the bed. RN 'H' explained R80 was unable to be freed from between the bed and the armoire without moving the nightstand on the opposite side of the bed and moving the bed away from the armoire. It was not until she got R80 unstuck that she was able to assess him and determined he was deceased . RN 'H' further explained the way R80 was positioned was unusual and could not have happened from a fall and likely did not happen during care. RN 'H' reported R80 was not a fall risk and was unable to move himself in bed. RN 'H' reported she notified the Administrator/Abuse Coordinator right away. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain general cleanliness and repair of plumbing and the ice machine, resulting in an increased potential for contamination including the water supply affecting all residents. Findings Include:On 3/30/2026 at 9:00 AM during a kitchen tour with dietary manager (DM) 'Z' observed sewer gas odor present near the sub floor grease trap by the 3-compartment sink. Also smelled the same odor at 3 in-floor drains, and near 3 kitchen sink drains. During this observation, when DM 'Z' was asked if he smelled this odor or knew what the issue was, DM 'Z' indicated having a diminished sense of smell and was not aware of the odor or what the issue may be. When asked about the frequency of service for the grease trap, DM 'Z' indicated about every 6 months and that the building was serviced by village of [NAME] sanitary sewer. On 3/30/2026 at 9:20 AM observed two kitchen sink drain lines (provide with sanitary air gaps to waste drain) with dark soil build up at the end of the drain line. On 3/30/2026 at 12:30 PM interviewed DM 'Z' further regarding grease trap maintenance procedures. When asked if there are service records, he said to ask of the maintenance supervisor or administrator. He also indicated that it would probably be a good idea to have it serviced more frequently. On 3/30/2026 at 12:50 PM interview with maintenance director (MD) 'W' indicated no plumbing service records are available, but he called the service company and last service was August 2025. MD 'W' indicated having the grease trap cleaned/serviced annually and the service company would be out to the facility tomorrow to investigate/provide service. MD 'W' said he has smelled the sewer gas odor and indicated that any service needs to be done by the professionals. According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. On 3/30/2026 at 9:50 AM observed the kitchen ice machine drip panel with spots of a pink substance forming. During this observation, when queried, DM 'Z' says the ice machine is deep cleaned quarterly and wiped down as needed. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. On 3/30/2026 at 10:15 AM observed the D Hall janitor sink connected to the chemical supply tower (with shut off valve). This water line is provided with an atmospheric vacuum breaker but is subject to back pressure. There is no wasting/vented T device provided to relieve the pressure in the line. On 3/30/2026 at 12:35 PM observed the garbage disposal sink with a submerged jet inlet located below the sink flood rim. There is also an air gapped over-sink faucet at this location. DM 'Z' showed that the water inlet valve to the garbage disposal is currently off and not used. When the valve was turned on and operated, water came out. There is currently no cross-connection prevention in place for this submerged inlet.According to the 2022 FDA Food Code section 5-203.14 Backflow Prevention Device, When Required.A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT, including on a hose [NAME] if a hose is attached or on a hose [NAME] if a hose is not attached and backflow prevention is required by LAW, by:(A) Providing an air gap as specified under S 5-202.13 P; or(B) Installing an APPROVED backflow prevention device as specified under S 5-202.14. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate an injury of unknown origin for one (R80) of six residents reviewed for abuse and neglect. Findings include:A review of R80's clinical record revealed R80 was admitted into the facility on [DATE], readmitted on [DATE], and expired in the facility on [DATE]. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R80 had moderately impaired cognition, one-sided impairment of the upper and lower extremities, was dependent on staff for toileting hygiene, rolling left and right, transferring, and going from sitting to lying. R80 did not stand or walk and had no history of falls. A review of R80's progress notes revealed the following: On [DATE] at 3:38 AM, Registered Nurse (RN) 'H' documented the following in a Nursing Progress Note, Resident last seen alive between 01:30 (AM) and 01:45 (AM) at which time he was repositioned, changed. At 02:08 (AM) nurse called to the room as resident observed out of bed. Nurse observed resident between bed and window with his shoulders off the floor, head stuck between bed and wardrobe face down. Unable to free resident's head until bed moved. Resident had no pulse, no respirations, No heart sounds on auscultation. Pronounced deceased at 02:13 (AM) by the nurse, RN. 911 called, administrator, DON (Director of Nursing), unit managers notified by phone . On [DATE] at 3:16 AM, Unit Manager, Licensed Practical Nurse (LPN), 'I' documented the same as the above progress note in a Nursing Progress Note.On [DATE] at 11:18 AM, the Administrator and DON were asked to provide any incident reports and investigations for R80 for the month of February 2026. A review of an incident report provided by the facility revealed on [DATE] at 2:08 AM, Resident last seen alive between 01:30 (AM) and 01:45 (AM) at which time he was repositioned, changed. At 02:08 (AM) nurse called to the room as resident observed out of bed. Nurse observed resident between bed and window with his shoulders off the floor, head stuck between bed and wardrobe face down. Unable to free resident's head until bed moved. Resident had no pulse, no respirations, No heart sounds on auscultation. Pronounced deceased at 02:13 (AM) by the nurse, RN . No documented investigation was provided with the incident report. On [DATE] at 2:14 PM, the Administrator was asked to confirm via email that there was no investigation associated with the above-mentioned incident report regarding R80's death. The Administrator replied that there was no specific investigation and that the notes were documented in the progress notes. On [DATE] at 3:55 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. When queried about whether she was notified about R80's death and how he was found, the Administrator reported the nurse (RN 'H') called her and said R80 was found on the floor with his head stuck between the bed and the dresser and that he was deceased . When queried about how that happened, the Administrator reported she did not know and asked LPN 'H' what she thought happened. According to the Administrator, RN 'H' said maybe R80 had a seizure but was not sure if he had a seizure disorder. The Administrator reported she did not conduct an investigation beyond talking to RN 'H' when she contacted her and stated, The Medical Examiner wasn't concerned so she did not look into it further. The Administrator reported she did not interview the CNA who provided care or who found R80 and did not interview R80's roommate. On [DATE] at 3:41 PM, an interview was conducted with the DON. When queried about R80 being found with his head stuck between the bed frame and armoire and his death and what was done to look into what happened, the DON reported it was not investigated and said it should have been. On [DATE] at 8:05 AM, an interview was conducted with RN 'H', who was the nurse assigned to R80 on the night shift on [DATE]-[DATE]. When queried about what happened with R80 on [DATE], RN 'H' reported she was called to the room by two Certified Nursing Assistants (CNAs), one of them being CNA 'J'. They told her R80 was out of bed. When RN 'H' entered the room, R80 was observed with his head face down stuck between the armoire and the bed frame with his feet forcefully wedged underneath the metal base of the over bed table that was beside the bed. RN 'H' explained R80 was unable to be freed from between the bed and the armoire without moving the nightstand on the<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | opposite side of the bed and moving the bed away from the armoire. It was not until she got R80 unstuck that she was able to assess him and determined he was deceased . RN 'H' further explained the way R80 was positioned was unusual and could not have happened from a fall and likely did not happen during care. RN 'H' reported she had never experienced anything like what she observed with R80. RN 'H' reported R80 was not a fall risk and was unable to move himself in bed. RN 'H' reported she notified the Administrator/Abuse Coordinator right away. On [DATE] at 8:30 AM, an interview was conducted with CNA 'J' who was assigned to R80 on the night shift of [DATE]-[DATE]. CNA 'J' was asked to explain any interaction and/or care provided to R80 on that shift and to describe what happened when he was found deceased . CNA 'J' confirmed she was the CNA assigned to R80 and checked on R80 every two hours throughout the shift. CNA 'J' explained the nurse got her at some point to re-center R80 in bed because he was trying to crawl out of the bed and was on the edge. CNA 'J' repositioned R80 with another CNA at that time. CNA 'J' further reported she had to reposition R80 in the bed twice that shift because he was on the edge. Later in the shift, CNA 'J' responded to R80's roommate whose tube feeding machine was beeping and she noticed R80 on the floor. CNA 'J' got RN 'H' who came to the room immediately. R80's head was wedged face down between the bed frame and the armoire and his body was on the floor with his feet underneath the over-bed table. They were unable to get R80's head out and had to move the nightstand and the bed to pull his head out. When RN 'H' assessed R80, he was not breathing. CNA 'J' explained R80 was not a fall risk and did not have a history of falls but would sometimes try to get out of bed. When queried about whether she was interviewed by Administration after the incident, CNA 'J' said Not until yesterday. A review of a facility policy titled, Abuse, Neglect and Exploitation, revised 9/2025, revealed, in part, the following, .Possible indicators of abuse include, but are not limited to .Physical injury of a resident, of unknown source .An immediate investigation is warranted when suspicion of abuse, neglect of exploitation, or reports of abuse, neglect or exploitation occur .Investigations may include but not limited to .Providing complete and thorough documentation of the investigation . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive care plan to address a resident's ileostomy [surgically created opening to allow waste to exit the body] for one [R35] of one resident reviewed for ostomies. Findings include:On 3/30/26 at 9:11 AM, R35 was observed sitting on the side of the bed. R35 was asked about care at the facility. R35 explained she had an ileostomy and needed assistance emptying and changing the bag. Review of the clinical record revealed R35 was admitted into the facility on 2/25/26 with diagnoses that included: kidney disease, osteoarthritis and ileostomy status. According to the Minimum Data Set [MDS] assessment dated [DATE], R35 had intact cognition and had an ostomy.Review of R35's comprehensive care plan revealed no care plan for an ileostomy.On 3/31/26 at 1:13 PM, the Director of Nursing [DON] was interviewed and asked if a resident should have a care plan for an ileostomy if they had one. The DON explained if a resident had any type of ostomy, it should be in the care plan.Review of a facility policy titled, Care Planning revised 6/2023 read in part, .The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. Any special needs. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>This citation pertains to intake 2801923.Based on observation, interview, and record review, the facility failed to thoroughly assess and document a change in condition for one (R79) of two residents reviewed for changes in condition. Findings include: On 3/30/26 at 10:13 AM, R79 was observed in bed. He was holding himself between his legs with his feet pressed against the foot board. R79 had some twitching movements and appeared disheveled. When spoken to, R79 mumbled and was difficult to understand. On 3/30/26 at approximately 11:00 AM, R79 was observed exiting the facility on a stretcher with EMS (Emergency Medical Services) staff. On 3/30/26 at 1:00 PM and 3:30 PM a review of R79's clinical record revealed R79 was sent to hospital in a Medication Administration Note. There was no documentation of why R79 was sent to the hospital. Further review on 3/31/26 at 9:00 AM and 1:14 PM, revealed no progress notes that documented why R79 went to the hospital on 3/30/26. Progress notes indicated R79 returned to the facility on the same day, 3/30/26. On 3/31/26 at 8:55 AM, R79 was observed lying in bed receiving oxygen via nasal cannula. R79 was able to participate in an interview on that date. R79 confirmed he was sent to the hospital the previous day but said he did not know why he went and that they sent him after he woke up. R79 expressed not feeling well and having difficulty breathing, but it was likely due to anxiety and would receive his anxiety medication soon. A review of a R79's assessments on 3/31/26 at 12:15 PM revealed no transfer form or change of condition assessment was completed for R79 to indicate what was going on with the resident. There was no progress note that documented R79 was readmitted into the facility. A review of R79's physician's orders revealed no order to send R79 to the hospital on 3/30/26. On 3/31/26 at 12:31 PM, an interview was conducted with the Director of Nursing (DON). When queried about what the expectation was for assessment and documentation if a resident had a change in condition and was sent to the hospital, the DON reported there should be a discharge emergent note in the progress notes, a physician's order to send to the hospital, and an E interact transfer form that included the assessment of the resident at the time of the change in condition. When queried about why R79 was sent to the hospital on 3/30/26, the DON said Unit Manager, Licensed Practical Nurse (LPN) 'K' and LPN 'M' sent him to the hospital and would have more information. The DON reviewed R79's clinical record and confirmed there was nothing documented according to the facility's policies and procedures and it should have been. On 3/31/26 at 12:50 PM, an interview was conducted with LPN 'K'. When queried about why R79 was sent to the hospital on 3/30/26, LPN 'K' said the nurse came to get him and said R79 was not verbally responding. LPN 'K' and LPN 'M' assessed R79 together and checked his vital signs which were within normal limits, but he was not responding and R79's son who worked in the facility said something was not right with the resident. R79 was then sent to the hospital. LPN 'K' reported LPN 'M' should have completed a discharge emergent note, obtained a physician's order, and completed a transfer form. LPN 'K' reported R79 had a change in condition a couple days prior but was not sent to the hospital. A review of R79's progress notes revealed a not dated 3/28/26 that noted, Patient told aide that he was having trouble breathing. I went into the room and checked his O2 (oxygen) saturation. Patient was stating at 68 (percent) on 4L (liters). I got patient a non-rebreather on 6L. Patient's O2 is at 96. Patient is back on nasal cannula. Dr. notified. The note was written by LPN 'X'. Further review of R79's clinical record revealed an incomplete change of condition assessment that was left blank and no documentation of what the physician's response was or if they were able to get ahold of them. On 3/31/26 at 1:34 PM, an interview was conducted with LPN 'X'. When queried about R79's change in condition on 3/28/26, LPN 'X' reported she contacted Physician 'Y' via text and made her aware R79's oxygen dropped, required a re-breather, and came back up. LPN 'X' said Physician 'Y' instructed LPN 'X' to monitor R79's oxygen level and gave specific parameters for when to apply oxygen and how much to administer. However, those instructions were not documented in the clinical record. A review of R79's clinical record revealed R79 was admitted into the facility on 3/25/26 with diagnoses that included: lung cancer. A<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | review of a facility policy titled, Change in Condition, revised 6/2023, revealed, in part, the following, .The organization utilizes an interaction platform in the electronic health record to recognize and manage a potential change in condition . There was no additional information about resident assessment or documentation included in the policy. |

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| | 235722 | A. Building<br>B. Wing | 04/01/2026 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2966880Based on observation interview and record review the facility failed to ensure physician/extender pressure ulcer treatment orders were followed for one [R55] of one resident reviewed for pressure ulcers. Findings include: A complaint was filed with the State Agency [SA] that read in part, .[R55] has bed sores on his bottom with [sic] are not always being taken care of. At times he has no bandages covering the sores and there is no cream or ointment placed on the sores.On 3/30/26 at 9:24 AM, R55 was observed sitting in a wheelchair in his room. R55 was asked if he had any wound or sores on his body. R55 explained he had a wound on his bottom. R55 was asked if the wound was getting better, worse or staying the same. R55 explained he did not know. When asked if the facility was doing treatments on the wound, R55 explained they did sometimes.Review of the clinical record revealed R55 was admitted into the facility on 1/3/26 and readmitted [DATE] with diagnoses that included: acute and chronic respiratory failure, diabetes and heart failure. According to the Minimum Data Set [MDS] assessment dated [DATE], R55 had moderately impaired cognition.Review of an Weekly Skin Sweep for R55 dated 2/17/26 revealed R55 had an open area on the coccyx.Review of a wound consult for R55 dated 2/18/26 read in part, .Wound #1 Coccyx is a Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer. Initial wound encounter measurements are 1.8cm [centimeters] length x 2cm width x 0.1cm depth. Wound bed has 30% granulation, 70% slough [non-viable yellow, tan, gray, green or brown tissue]. Plan: .Cleanse wound with Normal Saline. Apply Medihoney Gel [product that supports wound healing and removes necrotic tissue] QDay/PRN [every day/as needed]. Cover with secondary dressing(s). Plan of Care discussed with Treatment Nurse.Review of wound consults for R55 dated 2/25/26, 3/4/26 and 3/11/26 revealed documentation of Wound #1 as an Unstageable Pressure Injury and the treatment plan continued to be to cleanse wound with Normal Saline and apply Medihoney Gel and cover with a dressing every day and as needed.Review of wound consults for R55 dated 3/18/26 and 3/25/26 revealed documentation of Wound #1 as an Unstageable Pressure Injury and the treatment plan added calcium alginate [product that aids in debridement] along with the continued use of NS and Medihoney with a dressing every day and as needed.Review of R55's February 2026 Treatment Administration Record [TAR] revealed the only treatment for R55's bottom read May apply barrier cream to buttocks BID [two times a day] PRN every shift for skin with a start date of 2/17/26. Review of R55's March 2026 TAR revealed a treatment that read, Cleanse coccyx w/NS [with Normal Saline]. Pat Dry. Apply Medihoney to wound bed. Cover w/ boarder dressing. Every day shift for wound care with a start date of 3/12/26.On 4/1/26 at 9:15 AM, observation of R55's wound with the Consultant Wound Care Physician Assistant [PA] ?L' revealed a wound that appeared almost completely obscured with yellow slough. PA ?L' explained it was an Unstageable Pressure Injury, measured it to be 2 cm x 1.6 cm x 0.1 cm, 90% slough and 10% granulation tissue.On 4/1/26 at 9:20 AM, PA ?L' was interviewed and asked if she had ordered the treatment on R55's wound to be Medihoney from the first time she had seen R55 on 2/18/26. PA ?L' explained she had ordered Medihoney from the beginning. PA ?L' was asked if she put her own orders into the electronic medical record [eMAR]. PA ?L' explained she did not, she would tell the Wound Coordinator who rounded with her and they would put the orders into the eMAR. PA ?L' also explained the Wound Coordinator was usually Unit Manager [UM] ?K', but he had been doing other things for approximately three weeks and someone else had been acting as the Wound Coordinator. PA ?L' was asked if she had been aware the facility had not started using Medihoney until 3/12/26, approximately a month after she had ordered it on 2/18/26. PA ?L' explained she had not known that. PA ?L' was asked if the lack of Medihoney could have delayed the wound from healing. PA ?L' explained it could have delayed the healing; she had been concerned about the wound not healing and staying an Unstageable and had added the calcium alginate because it was not healing.On 4/1/26 at 9:23 AM, UM ?K' was interviewed and asked<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | about R55's wound treatment not including Medihoney for a month after PA ?L' ordered it. UM ?K' explained he would look into the issue.On 4/1/26 at 10:25 AM, the Director of Nursing [DON] was interviewed and asked if treatment orders from the Wound Consultant should be entered into residents' TAR. The DON explained all treatment orders should be entered into the TAR and initiated. When asked why R55's order for Medihoney not being initiated for a month, the DON explained she would look into it.On 4/1/26 at 10:38 AM, UM ?K' explained when R55 was admitted , there was an order to clean the wound with Normal Saline and a place a dry dressing until wound care could be consulted.Review of R55's discontinued physician orders revealed an order dated 2/17/26 that read, Cleanse coccyx with normal saline, pat dry and apply Border gauze or coccyx dressing to ensure wound healing until seen by wound care team. The order was discontinued on 2/17/26 and was never documented as having been done. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to consistently implement fall prevention interventions according to the resident's plan of care for one (R52) of two residents reviewed for falls. Findings include: On 3/30/26 at 9:24 AM, R52 was observed sleeping in bed. A walker and a wheelchair was observed in the room and were placed across the room near the window, not at bedside. When R52's name was called he did not wake up or respond. On 3/30/26 at 2:25 PM, R52 was observed sleeping in bed. R52 was lying horizontally on the bed with his feet and legs partially hanging off the side of the bed. A walker and wheelchair were observed near the window, not at bedside. On 3/30/26 at approximately 11:00 AM, a review of R52's care plans on 3/30/26 revealed the following: A care plan initiated on 5/7/25 and revised on 3/20/26 that noted, I have potential for injury r/t (related to) hx (history) falls, weakness, poor safety awareness, routine psych (psychotropic) med (medication) use, Parkinsonism w/ (with) impaired gait. An intervention initiated on 3/10/25 noted, .ensure that walker is next to bed during all rounding, and during med pass q (every) shift . On 3/31/26 at approximately 8:45 AM, a review of R52's progress notes revealed R52 had a fall on 3/24/26 and was observed on the floor of his room lying on his left side. R52 reported he was getting up to go to the bathroom. A review of a Nursing: Antigravity Team Note dated 3/25/26 revealed R52 had a fall on 3/24/26 and the root cause of the fall was documented as Unassisted ambulation to bathroom. It was documented a prior intervention was ensure that walker is next to bed during all rounding, and during med pass. On 3/31/26 at 9:00 AM, R52 was observed sleeping in bed. R52's walker was observed by the window and not at bedside. On 3/31/26 at 9:15 AM, an interview was conducted with the Director of Nursing (DON) who reviewed R52's clinical record and confirmed R52's walker should have been at bedside as it was a care planned intervention. The DON reported staff should move it to bedside if they notice it is not there. Further review of R52's clinical record revealed R52 was admitted into the facility on 3/26/21 and readmitted on [DATE] with diagnoses that included: dementia and Parkinson's Disease. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R52 had moderately impaired cognition and had a history of falls. |

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| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure nephrostomy tube [surgically implanted catheter into the kidney to drain urine] drainage bags were positioned correctly for dependent drainage for one [R25] of one resident reviewed for nephrostomy tubes. Findings include:On 3/30/25 at 9:34 AM, R25 was observed lying in bed. A drainage bag was lying on an overbed tray table positioned above the height of the bed on R25's right side. A second drainage bag was lying on a pillow propped against the wall on R25's left side, positioned above the height of R25 lying in bed. Both bags and tubing did not appear to have drainage fluid. R25 was asked what the drainage bags were connected to. R25 explained they were connected to his back. When asked if they were nephrostomy tubes in his kidneys, R25 agreed.On 3/30/26 at 12:35 PM, R25 was observed lying in bed. The nephrostomy tube drainage bags were still positioned above the level of R25's kidneys with no drainage fluid in bags or tubing.Review of the clinical record revealed R25 was admitted into the facility on 2/26/26 with diagnoses that included: acute kidney failure, cancer of the bladder and hydronephrosis [buildup of urine in the kidney]. According to the Minimum Data Set [MDS] assessment dated [DATE], R25 had a Brief Interview for Mental Status [BIMS] exam of 12/15 indicating moderately impaired cognition.Review of R25's physician orders revealed an order with a start date 3/3/26 that read, Keep Nephrostomy tubing taped to skin and connected to a drainage bag placed below the level of kidneys.On 3/31/26 at 12:27 PM, both of R25's nephrostomy tube drainage bags were observed lying on the tray table to R25's right side, above the height of the bed. The bags and tubing appeared empty.On 4/1/26 at 10:22 AM, the Director of Nursing [DON] was interviewed and asked how nephrostomy tube drainage bags should be positioned. The DON explained they should be below the level of the kidneys, due to they relied on dependent drainage the same as a urinary catheter. When informed of the multiple observations of the drainage bags being above the level of the kidneys, the DON explained she wanted to see R25.On 4/1/26 at 10:23 AM, R25 was interviewed with the DON present. The DON asked R25 how his drainage bags got placed on the tray table. R25 explained the staff would put the bag up there when they emptied the bags. Review of a facility policy titled, Nephrostomy Tube Care and Maintenance , undated, read in part, .Drainage Bag Management: Positioning: Always maintain the drainage bag below the level of the kidney to prevent the backflow of urine. |