STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235723	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Center	2060 Health Drive Wyoming, MI 49519

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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 - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to secure prescription medications according to professional standards and facility policies for 5 of 5 resident's (Resident #25, Resident #10, Resident #39, Resident #56, and Resident #45) and for one of four medication carts reviewed. Findings: Resident #25 (R25)Review of an admission Record revealed R25 was an [AGE] year-old female who admitted to the facility on [DATE]. Review of a Self-Medication Administration Safety Screen (SMASS) for R25 completed 06/04/25 revealed R25 could administer the following medications to herself unsupervised by nursing staff: (1) Trelegy 100-62.5-25 mcg (micrograms) inhaler and (2) an Albuterol Sulfate inhaler. During an observation on 12/02/25 at 11:30 AM, R25 sat in her wheelchair speaking with a staff person from the activity department and a small plastic medication cup containing pills sat on the nurse's station counter. R25 then took the plastic medication cup of pills and self-prolled herself to the common area near the nurse's station. During an interview at the same time, R25 stated that the cup of medication belonged to her and that she was supposed to take them as soon as the nurse gave them to her but that she got distracted by talking with a staff member. R25 then took the medications without a nurse supervision. The SMASS completed on 06/04/25 for R25 did not include approval for R25 to self-administer and medications in pill form. Resident #10 (R10)Review of an admission record revealed R10 was a [AGE] year-old male who admitted to the facility on [DATE]. During an observation on 12/03/25 at 8:06 AM, the unlocked medication cabinet inside R10's room contained a cup of pre-set medications. During an observation on 12/03/2025 at 1:35 PM the pre-set cup of medications was no longer in the medication cabinet inside R10's room, however, the cabinet remained unlocked and contained multiple prescription 5% Lidocaine patches. Review of the EHR (electronic health record) for R10 did not reflect that R10 had been assessed to self-administer his own medications. Resident #39 (R39) Review of an admission Record revealed R39 was a [AGE] year-old male that last admitted to the facility on [DATE]. During an observation on 12/03/25 at 8:10 AM, the medication cabinet in R39's room was unlocked and held two small plastic medication cups that contained pre-set pills. One cup had R39's first name and 1200 written on it. The second cup had R39's first name and 1600 written on it. During an observation on 12/03/25 at 1:33 PM, R39 sat in a chair in his room next to a small table. On the table sat an empty plastic medication cup with R39's first name and 1200 written on it. R39 stated that he had taken his noon medications but had not yet thrown away the medication cup. Resident #56 (R56)Review of an admission Record revealed R56 was a [AGE] year-old female who admitted to the facility on [DATE].During an observation on 12/03/25 at 8:18 AM the medication cabinet in R56's room was unlocked and contained prescription medications including eye drops, solution for a breathing treatment, a gel for pain, and a rescue metered dose inhaler. Resident #45 (R45)Review of an admission Record revealed R45 was a [AGE] year-old female who admitted to the facility on [DATE]. During an observation on 12/03/25 at 1:39 PM, the medication cabinet in R45's room was unlocked and contained prescription medications including a Fluticasone inhaler, Atropine sulfate 1% drops, (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	solution for a breathing treatment, and an albuterol sulfate metered dose inhaler. During an interview on 12/03/25 at 1:44 PM Licensed Practical Nurse (LPN) E stated that nurses may not pre-set medications and that the medication cabinets in the residents' rooms must be locked at all times. During an observation of the 300 high hall medication-cart on 12/03/25 at 1:49 PM, the narcotic lock box was not secured and opened without the use of a key. During an interview on 12/03/25 at 2:45 PM Licensed Practical Nurse (LPN) F stated that he had pre-set medications for R10 and R39 but it was not the standard of practice. LPN F also stated that the medication cabinets in the resident's rooms should be locked at all times. During an interview on 12/04/25 at 7:50 AM, Registered Nurse (RN) H stated that nurses do not pre-set medications and that the medication cabinets in the resident's room must be locked at all times. Review of the facility policy Medication Storage and Access reflected .only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications are allowed to access medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access and scheduled controlled medications are stored separately from other medications in a locked drawer or compartment designated for that purpose. Review of the facility policy Administration of Drugs revealed .medications may not be set up in advance.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2680029. Based on observation, interview and record review, the facility failed to create and implement person centered care plans for two (R27 and R63) of 13 residents reviewed for care plans. Findings include:Resident #27 (R27)Review of a Face Sheet revealed R27 had pertinent diagnoses of dementia, mixed incontinence, and metabolic encephalopathy (brain disfunction). Review of a Nursing admission assessment dated [DATE] for R27 revealed she was incontinent of bowel and continent of bladder. She had a non-blanchable red area on the left medial buttock. Review of a Braden Scale for Predicting Pressure Sore Risk dated 9/30/25 upon admission revealed R27 had a moderate risk for skin breakdown. Review of the Care Plan dated 10/8/25 revealed R27 had an ADL self-care performance deficit. Interventions included but are not limited to: Showering/Bathing per schedule or as needed. (No schedule was implemented.) The Care Plan had a focus for potential impairment to skin integrity related to metabolic encephalopathy, Dementia, osteoarthritis, covid 19, weakness, limited mobility, incontinence, with interventions that included, but not limited to: BRIEF USE: Resident uses incontinence management products. Change per protocol, preference, and as needed. No toileting schedule documented. No Care Plan for MASD or risk for pressure ulcers. Review of the Order Summary for R27 revealed an order for Tamsulosin once a day for urinary retention. No diagnoses in the electronic medical record revealed urinary retention and no care plan focus/interventions for urinary retention. Resident #63 (R63)Review of a Face Sheet revealed R63 had pertinent diagnoses of chronic kidney disease, heart failure, dementia, diabetes. No diagnosis of hypothyroid. Review of the admission Minimum Data Set (MDS) dated [DATE] for R63 revealed he had occasional urinary incontinence and always continent of bowel. Not in the Care Plan. Review of the Order Summary for R63 revealed an order for Levothyroxine (hypothyroid medication). Not in the Care Plan. During several observations on 12/2/25 at 11:00 AM, 12/3/25 at 8:15 AM, 12/4/25 at 9:00 AM, R63's room had a strong urine smell that permeated throughout the room and bathroom. In an interview on 12/3/25 at 8:15 AM, Registered Nurse (RN) A reported R63 toilets himself and thinks he urinates on the floor. In an interview on 12/4/25 at 9:06 AM, Housekeeper (HK) B reported R63 may be missing the toilet and urinating on the floor. The bathroom floor is wet and sticky at times and thinks the mattress on the bed needs to be switched out. HK B reported she cleaned his room twice the day before. During an observation and an interview on 12/4/25 at 9:08 AM, Licensed Practical Nurse (LPN) C reported R63 will not use his call light and will toilet himself and thinks he may urinate on the floor. R63 will use a urinal at times. No interventions or revisions were added to the care plan. In an interview on 12/4/25 at 9:17 AM, Certified Nursing Assistant (CNA) D reported she thought R63's mattress had a strong urine smell even though it had been cleaned. CNA D reported R63 does wear a pull up brief and will urinate on himself sometimes. When asked how often he is offered toileting, CNA D reported she will offer toileting 8-9 times a day and R63 will have already urinated or be in the process of it. CNA D reported she did not know what else to do and agreed the room had a strong permeating urine smell. Review of the Physician Orders for R63 revealed he receives 80 milligrams (mg) of Lasix (Furosemide), a diuretic once a day in the mornings for congestive heart failure. (A normal dose is 20 - 80 mg). Not in the Care Plan. Review of the Care Plan for R63 revealed he can ambulate to the toilet as a one person assist with a wheeled walker. No toileting schedule, no continence/incontinence, or pullup briefs are on the Care Plan. No focus for diabetes was acknowledged on the care plan. Review of a Toileting Task documentation dated 11/5/25 to 12/3/25 revealed R63 had mixed continence/incontinence/incontinence two to three times a day most days and several days he was only toileted once. In an interview on 12/4/25 at 10:01 AM, the Director of Nursing (DON) reported R63 wants to be independent and the facility is trying to respect his dignity when it comes to his toileting. When staff toilet R63, he forgets he was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	already toileted. Staff find R63 up trying to urinate again right after they offer/assist with toileting him. He misses the urinal and has tried different urinals with no success. While discussing R63's use of diuretics which causes frequent urination, the DON reported the facility had not put R63 on a toileting schedule and suggested the facility could increase toileting assistance in the mornings after he receives his diuretic and increase the daily cleaning of the bathroom to control the urine smell. Discussed with the DON how the care plans do not reflect a person-centered approach or reflect resident focused care for R27 and R63 and the DON acknowledged the concern.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. This citation pertains to intake 2680029. Based on interview and record review, the facility failed to provide showers for one (R27) of 3 residents reviewed for activities of daily living (ADL). Findings include:Review of a Face Sheet revealed R27 had pertinent diagnoses of dementia, mixed incontinence, and metabolic encephalopathy (brain disfunction). Review of the Care Plan dated 10/8/25 revealed R27 had an ADL self-care performance deficit. Interventions included but are not limited to: Showering/Bathing per schedule or as needed. (No schedule was implemented.) The Care Plan had a focus for potential impairment to skin integrity related to metabolic encephalopathy, Dementia, osteoarthritis, covid 19, weakness, limited mobility, incontinence, with interventions that included, but not limited to: BRIEF USE: Resident uses incontinence management products. Change per protocol, preference, and as needed. No toileting schedule documented. Review of the Toileting task documentation dated 11/5/25 to 11/24/25 revealed R27 was documented as being continent or incontinent one to two times a day on most days. Review of an ADL task documentation and Shower sheets for R27 revealed in October (10/6/25 to 10/31/25) she received 2 showers. In November (11/1/25 to 11/24/25 (discharge), she received 3 showers. Review of a Skilled Charting document dated 11/23/25 for R27 revealed the resident had moisture associated skin damage (MASD) over her sacrum, coccyx, and buttocks. In an interview on 12/4/25 at 11:13 AM, the Director of Nursing (DON) reported that the system did not trigger the documentation for showers for staff and staff only documented showers on an as needed basis instead of a regular schedule. The standard of care requires facilities to bathe residents twice a week. When questioned about resident toileting documentation, the DON reported staff should document every time they toilet a resident or provide incontinence care and acknowledged that staff document it once a shift. When asked about R27's skin and the MASD, the DON reported R27 admitted with MASD on the left gluteal that cleared up and acknowledged that the resident developed more MASD that returned prior to her discharge.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to implement a person-centered toileting program for one (R63) of 1 resident reviewed for toileting. Findings include:Resident #63 (R63)Review of a Face Sheet revealed R63 had pertinent diagnoses of chronic kidney disease, heart failure, and dementia. During an observation on 12/2/25 at approximately 11:00 AM, R63 was just returning to his room with a Therapy Staff member when a strong urine smell was noticed throughout the room. The bathroom had a stronger smell, the floor was sticky when walked on, and the toilet had urine sitting in the toilet. A urinal was noticed hanging on the edge of the counter with some residual urine. During an observation and interview on 12/3/25 at 8:15 AM, R63 was in bed sleeping and did not smell urine but the bathroom had a strong urine smell. Registered Nurse (RN) A reported R63 toilets himself and thinks he urinates on the floor. RN A then asked the housekeeper to clean his bathroom well. During an observation and an interview on 12/4/25 at 9:00 AM, R63 was sitting up in his chair and a strong urine smell permeated throughout the room, including the bathroom. R63 had his call light close by and reported he never needed to use it. When asked if he needed assistance for toileting, R63 denied needing assistance. In an interview on 12/4/25 at 9:06 AM, Housekeeper (HK) B reported R63 may be missing the toilet and urinating on the floor. The bathroom floor is wet and sticky at times and thinks the mattress on the bed needs to be switched out. HK B reported she cleaned his room twice the day before. During an observation and an interview on 12/4/25 at 9:08 AM, Licensed Practical Nurse (LPN) C reported that R63's wife usually assists the resident at the facility with his activities of daily living (ADL's) including toileting R63. LPN C thinks the wife brings items from home that have a urine smell. LPN C went to R63's room and confirmed a strong smell and that the bathroom floor was sticky. LPN C reported R63 will not use his call light and will toilet himself and thinks he may urinate on the floor. R63 will use a urinal at times. In an interview on 12/4/25 at 9:17 AM, Certified Nursing Assistant (CNA) D reported she thought R63's mattress had a strong urine smell even though it had been cleaned. CNA D reported R63 does wear a pull up brief and will urinate on himself sometimes. When asked how often he is offered toileting, CNA D reported she will offer toileting 8-9 times a day and R63 will have already urinated or be in the process of it. CNA D reported she did not know what else to do and agreed the room had a strong permeating urine smell. Review of the Physician Orders for R63 revealed he receives 80 milligrams (mg) of Lasix (Furosemide), a diuretic once a day in the mornings for congestive heart failure. (A normal dose is 20 - 80 mg). Review of the Care Plan for R63 revealed he can ambulate to the toilet as a one person assist with a wheeled walker. In an interview on 12/4/25 at 10:01 AM, the Director of Nursing (DON) reported R63 wants to be independent and the facility is trying to respect his dignity when it comes to his toileting. Staff toilet R63, and he forgets. Staff find R63 up trying to urinate again right after they offer/assist with toileting him. He misses the urinal and has tried different urinals with no success. While discussing R63's use of diuretics which causes frequent urination, the DON reported the facility had not put R63 on a toileting schedule and suggested the facility could increase toileting assistance in the mornings after he receives his diuretic and increase the daily cleaning of the bathroom to control the urine smell.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain accurate documentation regarding the disposition of controlled substances for 1 of 2 resident's (Resident #62) reviewed. Findings:Resident #62 (R62) Review of an admission Record revealed R62 was a [AGE] year-old female last admitted to the facility on [DATE]. Review of a physician order revealed R62 was prescribed Morphine Sulfate (MS) oral solution 20mg (milligrams) / 5 ml (milliliters) give 0.25ml every 3 hours as needed for pain and shortness of breath. Review and comparison of the Controlled Substance Proof of Use Record (CSPUR) and the Electronic Medication Administration Record (Emar) revealed the following discrepancies as related to R62's use of MS: (1) a 0.25 ml dose of MS was signed out on 08/04/25 at 3:21 PM but was not documented as given on the Emar. (2) a 0.25 ml dose of MS was signed out on 08/05/25 at 8:30 AM but was not documented on the Emar as given to R62, (3) the Emar dated August 2025 reflected an order to discontinue the Morphine Sulfate at 11:59 PM on 08/05/25, however a dose was signed out on the CSPUR for R62 on 08/06/25 at 8:27 AM and again on 08/20/25 at 12:30 PM. No documentation was located in the electronic health record (EHR) that discussed whether or not R62 received either of the doses of MS that were signed out after the order had been discontinued, (4) further review of the CSPUR for R62 and the use of Morphine Sulfate 20mg/5ml reflected that the amount of the medication remaining on 08/20/25 was 19 ml. The next entry on the CSPUR for R62 was dated 10/19/25 and had a corrected remaining amount documented as 17 ml. No additional doses of MS had been documented on the Emar as given to R62 between 08/05/25 and 10/19/25, and (5) the following entry on the CSPUR for R62 was dated 11/06/25 and had a corrected remaining amount documented as 16 ml. No additional doses of MS had been documented on the Emar as given to R62 between 10/20/25 and 11/06/25. Review of a physician order revealed R62 was prescribed Oxycodone 5 mg one tab every 4 hours as needed for pain. Review and comparison of the Controlled Substance Proof of Use Record (CSPUR) and the Electronic Medication Administration Record (Emar) as related to R62's use of Oxycodone 5mg tabs revealed the following discrepancies: (1) a 5mg tab was signed out by nursing staff on 08/14/25 at 10:00 PM but was not documented on the Emar as given to the resident, (2) a 5mg tab was signed out on the CSPUR by nursing on 08/22/25 at 7:30 AM and was not documented on the Emar, (3) a 5mg tab was signed out on 08/22/25 at 7:32 PM and was not documented as given to R62 on the Emar, and (4) a 5mg tab of Oxycodone was signed out on 09/18/25 at 11:15 AM and there was no nurses' signature on the CSPUR. During an interview on 12/04/25 at 11:50 AM, the Director of Nursing (DON) stated that the expectation for nurses administering and documenting controlled substances was for the documentation on the CSPUR and Emar's to always match, there should always be signatures noting which nurse signed out the medication, and any discrepancy in the count/amount remaining of a controlled substance should be reported to the DON immediately.