STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235556	A. BUILDING ______ B. WING ______	**3/4/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodward Hills Health and Rehabilitation Center	**39312 Woodward Ave Bloomfield Hills, MI 48304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Woodward Hills Health and Rehabilitation Center was surveyed for a Recertification survey on 3/4/26. Intakes: 2721741, 2738896, 2745432. Census=154	F0000		
F0554 SS= D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were assessed for safe self-administration of medication for three residents (R27, R134 and R138) of three residents reviewed for self-administration. Findings include: R27 On 3/2/26 at 10:50 AM R27 was observed in their room in bed. It was further observed a medication cup containing seven pills was placed at the corner of their bedside table. At that time, R27 was asked about the pills and had no response. They were then more specifically asked if staff entered their room with the pills and left them on the table without them taking them and replied, "I	F0554	**Element 1** Resident #R27 and #R138 no longer reside within the facility. Resident #R134 continues to reside within the facility. The resident has been offered a Self-Administration evaluation and declines. **Element 2** Like residents are identified as residents that reside within the facility and have the ability to self-administer their own medications. Like residents that have been re offered to have the Self Administration Evaluation completed and care planned if applicable. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F554. 2.IDT reviewed the “Medication – Self Administration” policy and deemed appropriate. 3.The RN / LPN have been re-educated on the Medication – Self Administration policy with emphasis on ensuring medications are not to be left at bedside unless the resident has been determined to medication self-administration. 4.The Advocate Team will observe medications at bedside during daily rounds.	4/2/2026

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

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.

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	guess so." On 3/2/26 at 10:53 AM, a review of R27's electronic medication administration record was conducted and revealed Nurse 'V' documented seven medications scheduled for 9 AM as given. On 3/2/26 at 11:02 AM, an interview was conducted with Nurse 'V'. They were asked about the pills observed on R27's bedside table and said R27 told them they were going to take them. They were then asked if they remained in the room and observed R27 take their medications and had no response. On 3/3/26 at 11:27 AM, a review of R27's clinical record revealed they had no assessment, physician's order, or care plan for self-administration of medications. On 3/3/26 at 11:42 AM, an interview was conducted with the facility's Director of Nursing (DON). They were asked about the process to determine whether a resident was appropriate for self-administration of medications and said residents would be assessed, physician's orders would be written, and a care plan would be in place. They were then asked if a resident was not appropriate or assessed for self-administration, should the nurse administering the medications remain with the resident and said they should. Finally, the DON was asked to provide a list of residents in the facility who self-administered medications and said they could run a report and would provide it. On 3/4/26 at 9:16 AM, a review of facility provided report for residents where were assessed and deemed appropriate for self-		**Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Director of Nursing / Designee will audit 10 residents per week to ensure medications are not left at bedside unless the resident has been deemed appropriate via a completed Self Administration assessment. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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	administration of medications was conducted, however; R27 was not on the list. R138 On 3/2/26 at 9:30 AM, R138 was observed in their room eating their breakfast. An observation of the sink and countertop in the room revealed four bottles of various supplements including a supplement for sleep, a multivitamin, a bottle of protein supplements and a bottle of magnesium supplements. On 3/3/26 at 11:25 AM, a second observation of R138's room continued to reveal the four bottles of supplements on the sink countertop. On 3/3/26 at 11:48 AM a review of R138's clinical record revealed they had no assessment, physician's order, or care plan for self-administration of medications. On 3/4/26 at 9:16 AM a review of a facility provided report for residents where were assessed and deemed appropriate for self-administration of medications was conducted, however; R138 was not on the list. A review of a facility provided policy titled, "Medication-Self Administration" reviewed 2/2026 was conducted and read, "...Each resident is offered the opportunity to self-administer medications. If the resident requests to do so, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident...The Medication Self-Administration Safety Screen in (electronic medical record name) will be			

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	completed by the licensed nurse...If it is deemed safe and appropriate for a resident to self-administer medications this is documented in the physician orders, medical record, and the care plan..." R134 On 3/02/2026 at approximately 11:26 a.m., R134 was observed in their room, sitting in their wheelchair. R134 was observed to have two antacid tablets in a medication cup on their bedside table. R134 was queried regarding the medications, and they indicated the Nurse had left them there for them after they received their morning medications. R134 was asked if the Nursing staff had left medications for them to take before and they reported they had. On 3/2/26 the medical record for R134 was reviewed and revealed the following: R134 was initially admitted to the facility on 2/4/26 and had diagnoses including Congestive heart failure and Dysphagia. A review of R134's medications revealed the following: "Calcium Carbonate Tablet Chewable 500 MG Give 2 tablet by mouth three times a day for Indigestion; Upset Stomach before meals" Further review of R134's medical record did not reveal any Physician orders to self-administer medications. R134's careplan did not indicate that self-administration was part of their plan of care or that R134 had been assessed for safe self-administration of medication.			
F0576 SS= D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9)	F0576	**Element 1** Resident #R127 continues to reside within the facility. The resident has been interviewed to confirm he has not had any further mail	4/2/2026

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	§483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law.		opened by the facility. **Element 2** Like residents are identified as residents that reside within the facility. The mail delivery has been audited to ensure it is being distributed unopen by facility staff. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F576. 2.IDT reviewed the “Resident Council Meetings” policy and deemed appropriate. 3.IDT reviewed “Resident Information Handbook” and deemed appropriate. 4.The Business Office Manager and the Director of Nursing have been re-educated on F576 with emphasis on not opening residents’ mail without permission. **Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Administrator / Designee will interview 10 residents per week to ensure they received their unopen mail. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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	This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the resident rights of one Resident (R127) of three residents reviewed for resident rights, related to privacy with opening their own mail. Findings include: On 3/03/26 at 11:03 a.m., a group meeting was held with facility residents to review the facility resident council process. On 3/03/26 at approximately 12:00 p.m., R127 reported two weeks prior they received their mail opened, which upset them. R127 clarified the mail opened by facility staff was a statement from their insurance company, Medicaid or Medicare. R127 said, “It (the letter) was addressed to me. It was a statement about payments.” R127 explained they had only been made aware by a surveyor there was a resident council meeting and concern review process. R127 said they were grateful to be heard. R127 was interviewable and oriented to themselves, their situation, place, and could tell time. Review of R127’s profile revealed they were their own responsible party, with “bills” marked. Review of R127’s Minimum Data Set (MDS)			

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	assessment, dated 1/21/26, revealed R127 was admitted to the facility on 10/16/25, with diagnoses including diabetes, heart failure, lung disease, depression, and malnutrition. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 11/15, which showed R127 had moderate cognitive impairment. On 3/04/26 at 1:41 p.m., the Business Office Manager, Staff “G”, was asked if they had opened any of R127’s mail, with the Director of Nursing (DON) present. Staff “G” acknowledged they had opened R127’s application for Medicaid and said they had been authorized by R127’s attorney. Staff “G” reported R127 had let them know this bothered them afterwards when R127 had received the letter opened. Staff “G” said they and R127 “had a conversation” regarding their concern. Staff “G” and the DON reported they understood the concern related to residents’ rights to open their own mail. Review of the policy, “Resident Council Meetings”, revised 3/03/26, revealed, “This facility supports the rights of the residents to organize and participate in resident groups in the facility…” “Resident group” is defined as a group of residents that meets regularly to discuss and offer suggestions about facility policies and procedures affecting resident care, treatment, and quality of life, support each other, plan resident and family activities, participate in educational activities, or for any other purpose…8…Examples of meeting topics: Resident rights…Resident mail procedures…”			

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	Review of the “Resident Information Handbook”, viewed in the general admission contract documents provided to residents upon admission, revealed on Page 31: …” Our facility. Just as you value your choices, we value respecting them. (Facility) person-centered care focus allows for individuality, preferences, and dignity coupled with a sense of community. Our philosophy of person-centered care means that you will receive the help and support you need to reach your health care goals without losing choice and autonomy…” The handbook further revealed on Page 34, “…Mail: Mail and other deliveries will be brought to your room…”			
F0677 SS= D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by:	F0677	**Element 1** Resident #R197 no longer resides within the facility. Resident #R186 continues to reside within the facility. The resident received a shower, nail care, and lotion to dry skin. **Element 2** Like residents are identified as residents that reside within the facility. Like residents received bathing per their plan of care and documented in the medical record.	4/2/2026

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	Based on observation, interview and record review, the facility failed to ensure routine bathing was provided for two residents (R186 and R197) of five residents reviewed for activities of daily living (ADL's). Findings include: R197 On 3/02/2026 at approximately 9:44 a.m., R197 was observed in their room, lying in their bed. R197 was asked if they had any concerns regarding their care in the facility and they reported they were only being offered bathing once a week and the schedule was supposed to be twice a week. R197 reported that they ask staff about their shower days they receive a "blank stare". R197 was asked if they have refused showers/bathing and they reported they had not. On 3/3/26 at approximately 11:06 a.m., R197 was queried if they have been offered any bathing and the indicated that nobody has told them about their showers. R197 reported that the staff "dodge" the question. On 3/2/26 the medical record for R197 was reviewed and revealed the following: R197 was initially admitted to the facility on 1/31/26 and had diagnoses including Infection and Inflammatory reaction due to due to internal right knee prosthesis. A review of R197's MDS (minimum data set) with an ARD (assessment reference date) of 2/6/26 revealed R197 needed substantial assistance from facility staff with bathing. A review of R197's careplan revealed the following: "Focus-ADL self-care deficit related to generalized weakness, impaired mobility 2/2 (secondary)R (right) knee PJI		**Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F677. 2.IDT reviewed the “Activities of Daily Living (ADL)” policy and deemed appropriate. 3.The RN/LPN/CENA have been re-educated on the activities of daily living policy with emphasis on completing scheduled bathing and documentation in the medical records. 4.The clinical team will review shower completion in the morning clinical meetings daily. **Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Director of Nursing / Designee will audit 10 residents per week to ensure they received their bathing per there plan of care and it has been documented in the medical record. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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	(prosthetic joint infection) Date Initiated: 01/31/2026...Interventions-Assist to bath / shower as preferred per shower schedule and as needed. Date Initiated: 01/31/2026..." A review of R197's documentation of being offered bathing for the prior 30 days revealed the following: Certified Nursing Assistant (CNA) Task documentation revealed R197 was provided shower on 2/5/26. One bathing refusal was noted on 3/3/26. A review of R197's "shower sheets" revealed one shower sheet in which R197 received a shower on 2/20/26. A review of R197's skin assessments reveled R197 received a shower on 2/24/26. On 3/4/26 at approximately 1:31 p.m., the Director of Nursing (DON) was queried regarding the provision of routine bathing, and they reported that bathing should be offered twice a week. The DON was informed of the lack of documentation that R197 was being offered bathing twice a week and they repeated that bathing should be offered twice a week. At that time, the DON was asked to provide any additional documentation for R197's bathing and none was received before the end of the survey. R186 Clinical record review revealed R186 was admitted to the facility on 5/8/2023 and had significant complications with diabetes including peripheral neuropathy (nerve damage causing lack of feeling) and resulted in a Left Below Knee Amputation (LBKA). R183 had declined in Activities of Daily Living (ADL's) related to mild cognitive impairment, but was alert, orientated and			

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	able to make their needs known. The Minimum Data Set (MDS) assessed on 2/9/26 revealed a Brief Interview Mental Status (BIMS) score of 12/15, indicating cognitive impairment. On 3/02/2026 at 10:10 AM, initial introduction and observation with R186 revealed them alone in room in their wheelchair. Their hair was disheveled; all fingernails were observed long and dirty. A strong odor of urine was noted which became more intense closer to R186. A clothing protector was observed heavily soiled with dried food, liquid matter that covered them from neck to waist and the navy-blue t-shirt sleeves and pants were observed stained with dried food and crumbs. Food and crumbs were also observed amongst the wheelchair seat. R186 spoke of their left leg prosthetic and wanted to share how their right foot was healing. R186 voluntarily removed their right sock, revealed very dry skin flaking off onto the floor and a strong pungent odor was immediately noticed. A shower sign posted above their bed read shower days were Monday and Thursday between 3:00 and 11:00 PM. When questioned when their last shower was, R186 stated showers are “an issue” and could not recall the last time they had one. On 3/02/2026 at 11:36 AM, R186 was observed in same clothes with dirty clothing protector self-propelling down the common hall. R186 had a table tray and a box of microwaveable lasagna. As they passed by, R186 was observed interacting with another resident, and the smell of urine odor was very apparent and became stronger the closer contact with R186.			

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On 3/2/26 at 1:23 PM, a review from the last 30 days (February 2026) for R186 documented Task Shower/Bath:

2/2/26 at 21:55 charted Not applicable. No reference to meaning.

2/9/226 at 22:09 a shower was performed.

2/23/26 at 21:44 residents refused.

On 3/3/26 at 2:30 PM, R186 were observed in room sitting in their wheelchair entertained with their electronics. Upon entrance the notable smell of urine was identified and became stronger the closer contact. R186 was observed wearing the same soiled navy-blue colored t-shirt with soiled pants as observed on 3/2/26. When asked if a shower was provided the night before, R186 replied “no”. When asked if they refused, they replied no, they “…just never got it…”

On 3/3/2026 at 2:30 PM, an interview with the Unit Manager Registered Nurse (RN) “D” was asked to aid to locate where the Certified Nurse Assistants (CNA’s) would document progress notes regarding showers for R186. RN “D” was observed looking into R186’s electronic medical record (EMR) and indicated they could not locate where the CNA’s document in the Task area and would have to ask the Director of Nursing (DON). When questioned if there was any documentation elsewhere, such as a progress note, RN “D” replied there was nothing in the progress note, but there might be a completed a shower sheet. RN “D” explained the process for shower sheets that once completed, the CNA places into a bin at the nurse’s station and then medical records picks them up the following day. RN “D” said

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	CNAs can document on the shower sheet if a resident refuses. On 3/3/26 at 2:40 PM, Medical Records Coordinator “U” retrieved the last 30 days of shower sheets for R186 and revealed only one shower sheets was archived. The sheet was dated for 2/23/26 and was checked resident refused “…resident stated he will take it on Thursday…” On 3/3/26 at 3:30 PM, a clinical record review of R183’s progress notes authored by RN “D” documented an effective date of 3/2/26 19:45 Nursing Progress note “Resident offered shower by assigned CNA refused scheduled on 3 separate attempts. Writer will follow-up on 03-03-2026…” On 3/3/26 around 4:00 PM, The DON and RN “D” were asked to come to the conference for an interview. When inquired how previous requested documentation that they claimed was unavailable was now in R186’s progress, RN “D” said they had learned how to chart in the Task area and called the CNA from 3/2/26 and back dated the progress note that R186 had refused. RN “D” remarked that when a resident refuses three times, the CNA tells the assigned nurse, and sometimes they as the unit manager must assist if there are three refusals. When questioned if this was the case on 3/2/26, then why was this not communicated during the interview, RN “D” did not provide an explanation. Final record review revealed for the month of February 2026, a total of eight opportunities for a shower, R186 was documented have been only offered only three showers.			

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	Record review of R186's care [lan documented "resident has an ADL self-care performance deficit r/t <sic> generalized weakness and fatigue, left BKA…" Initiated on 8/20/25. Interventions for R186 included Bathing/Showering: Check nail length and trim and clean on bath day. Continue to offer showers on shower day.			
F0684 SS= D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: This citation pertains to intake 2745432. Based on interview and record review, the facility failed to ensure medications were available for administration and Physician orders were clarified with the Physician/pharmacy for one resident (R204) of one resident reviewed for medication administration, resulting in R204 having missed doses of their Physician-ordered medications. Findings include: On 3/2/26 a concern submitted to the State	F0684	**Element 1** Resident #R204 no longer resides within the facility. **Element 2** Like residents are identified as residents that reside within the facility. Like residents have been audited to ensure they are receiving their medications per physician orders. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F684. 2.IDT reviewed the "Medication Administration" policy and deemed appropriate. 3.The RN/LPN have been re-educated on the medication administration policy with emphasis on dispensing medications per physician order and to contact the provider for further orders if medications are not available. 4.The clinical team will review missed medications in the morning clinical meetings daily via the PCC dashboard labeled "Med pass in the last 24 hours" **Element 4** The process to ensure that the specific citation remains corrected includes:	4/2/2026

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	Agency was reviewed which alleged R204 was not administered their medications according to the Physician's orders. On 3/3/26 the medical record for R204 was reviewed and revealed the following: R204 was initially admitted to the facility on 8/9/25 and had diagnoses including Malignant neoplasm of brain and Malignant neoplasm of lymph nodes of multiple regions. A progress note dated 8/21/25 revealed the following: "A progress note revealed the following: "8/21/2025 16:34Nursing - Progress Note-Note Text: Radiologist ordered Namenda titration pack for 1 month, then 10 mg (milligrams) daily for 5 months. writer reviewed correct dosing with pharmacist from...pharmacy...." A Physician order dated 8/21/25 with a start date of 8/22/25 revealed the following: "Namenda Titration Pak Oral Tablet (Memantine HCl) Give 5 mg by mouth one time a day for dementia for 7 Days -Start Date- 08/22/2025 0900 -D/C Date 09/05/2025" A second Physician order with a start date of 8/30/25 revealed the following: "Namenda Titration Pak Oral Tablet (Memantine HCl) Give 5 mg by mouth two times a day for dementia for 7 Days -Start Date- 08/30/2025 2100 -D/C Date- 09/05/2025" A review of R204's August and September 2025 medication administration record (MAR) revealed R204 was not administered doses of their namenda on 8/23, 8/24, 8/25, 8/30, 8/31, 9/1 and 9/2. A review of R204's electronic medication		1.The Director of Nursing / Designee will audit 10 residents per week to ensure they are receiving their medications per physician orders. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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	administration (eMAR) notes pertaining to their nameda administration (EMAR) revealed the following: "08/22/2025 14:24 Type: Physical Medicine and Rehabilitation:..8/22: Pt (patient) was started on a namenda titration pak by radiation/oncology..." "08/23/2025 10:14 Type: eMAR - Administration Note: "Namenda Titration Pak Oral Tablet Give 5 mg by mouth one time a day for dementia for 7 Days patient medication is not available contacted pharmacy, medication needs clarification and has to be broken differently contacted supervisor on staff writer was told to put a note in mar and supervisor would contact D.O.N.(Director of Nursing) There are no further concerns at this time." "08/24/2025 09:11 Type: eMAR - Administration Note: "Namenda Titration Pak Oral Tablet Give 5 mg by mouth one time a day for dementia for 7 Days pt medication is not available and needs to be clarified per pharmacy" "08/25/2025 08:42 Type: eMAR - Administration Note: "Namenda Titration Pak Oral Tablet Give 5 mg by mouth one time a day for dementia for 7 Days not in back up box" "08/30/2025 22:08 Type: eMAR - Administration Note: "Namenda Titration Pak Oral Tablet Give 5 mg by mouth two times a day for dementia for 7 Days unavailable" "08/31/2025 22:05 Type: eMAR - Administration Note: "Namenda Titration Pak Oral Tablet Give 5 mg by mouth two times a day for dementia for 7 Days unavailable" "09/01/2025 08:46 Type: eMAR - Administration Note: "Give 5 mg by mouth two times a day for dementia for 7 Days pt medication is not available and needs to be			

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clarified per pharmacy"
"09/02/2025 08:10 Type: eMAR - Administration Note "Namenda Titration Pak Oral Tablet Give 5 mg by mouth two times a day for dementia for 7 Days patient medication is not available"
"09/02/2025 21:08 Type: eMAR - Administration Note "Namenda Titration Pak Oral Tablet Give 5 mg by mouth two times a day for dementia for 7 Days na (not available)"
"09/13/2025 17:27 Type: Physician Team - Progress Note: "Patient has all the medications reviewed as following; Namenda 10 mg 1 p.o. (by mouth) daily...Plan of care; Patient's all the medications reviewed and continued.."

Further review of the September 2025 MAR and Physician orders revealed R204 did not receive any namenda after 9/5/25.

On 3/4/26 at approximately 1:31 p.m., R204's medical record was reviewed with the DON, who reported they were not the DON during the period R204 was in the facility and that R204's namenda medication orders should have been clarified with the pharmacy and the Physician to ensure the medication would be delivered and available to be administered.

On 3/4/26 a facility document titled "Medication Administration" was reviewed and revealed the following: "Policy overview- To safely and accurately prepare and administer medication according to physician order, professional standards of practice, and resident needs....Administer medication in accordance with frequency prescribed by physician and standards of practice....If a

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	pharmacy supplied medication is not available, refer to the pharmacy policy and procedures related to emergency pharmacy delivery and emergency supply kit usage..."			
F0686 SS= D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: This citation pertains to intake 2745432. Based on interview and record review, the facility failed to ensure wound treatments were provided for one resident (R204) of two residents reviewed for pressure ulcers. Findings include: On 3/2/26 a concern submitted to the State	F0686	**Element 1** Resident #R204 no longer resides within the facility. **Element 2** Like residents are identified as residents that reside within the facility. Like residents have had a skin assessment completed. Treatment orders have been implemented if applicable. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F686. 2.IDT reviewed the “Skin and Wound Guidelines” policy and deemed appropriate. 3.The RN/LPN have been re-educated on the Skin and Wound Guidelines policy with emphasis on the need for an assessment if newly identified wounds are observed. 4.The clinical team will review alerts for new skin issues in the morning clinical meetings daily via the 24 hours communication report in PCC using key words to scrub any progress noted documenting a skin concern. **Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Director of Nursing / Designee will audit 10 residents per week to ensure newly identified skin issues have been assessed and treatment implemented. Audits will be conducted weekly for four weeks then monthly	4/2/2026

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	Agency was reviewed which alleged R204 developed pressure ulcers during their stay at the facility. On 3/3/26 the medical record for R204 was reviewed and revealed the following: R204 was initially admitted to the facility on 8/9/25 and had diagnoses including Malignant neoplasm of brain and Malignant neoplasm of lymph nodes of multiple regions. A review of R204's Physician evaluations revealed the following: 09/13/2025 at 17:27 Type: Physician Team - Progress Note: "Date of progress notes; 9/13/2025-Subjective symptoms; patient is not eating well and not drinking well. Patient want to more foodI <sic> recommended double the portions of the food for him to eat. Patient is developing skin breakdown on the lower back for which patient is getting wound care...Skin evaluation; lower back skin breakdown noted...Lower back skin breakdown secondary to severe malnutrition...Wound care to the lower back decubitus ulcer. Wound care team is following the patient..." 09/19/2025 at 10:00 Type: Physician Team - Discharge Note: "Lower back skin breakdown secondary to severe malnutrition...Physical examination before the discharge;...Skin evaluation; lower back skin breakdown noted...On the visit on 9/13/2025 patient requested more food I requested double the portions all the time besides the nutritional supplements after meals 3 times daily. Patient developed lower back skin breakdown due to malnutrition..." Further review of the medical record did not		for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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reveal any wound care treatments for the identified decubitus ulcer identified by the Physician on 9/13/26 or any follow-up assessments completed by the facility wound Nurse or Wound care provider that documented the presentation of the ulcer.

On 3/3/26 at approximately 3:24 p.m., R204's medical record was reviewed with Wound Care Nurse "T" (WCN "T"). WCN "T" was queried if they had ever assessed R204's decubitus ulcer on their lower back that was identified by the Physician on 9/13/25 evaluation and they reported they had not because the Physician and other Nursing staff did not inform them of the newly developed ulcer. WCN "T" was asked if any treatments were initiated when the new wound was identified. WCN "T" reviewed the record and reported that no treatments were implemented, and the wound presentation was never assessed by any of the facility wound care team members. WCM "T" reported the only skin treatment R204 received was a "perishield" barrier cream that was ordered upon admission as a skin protectant and that R204's wound was never provided a treatment.

On 3/4/26 at approximately 1:31 p.m., the DON (Director of Nursing) was queried regarding the identified decubitus ulcer for R204 and they reported they had been made aware of the concern the previous day, but they could not add anything to the concern that WCN "T" had not already provided the previous day as they were not working in the facility during the time of R204's stay.

On 3/4/26 a facility document titled "Skin and Wound Guidelines" was reviewed and revealed the following: Policy Overview-To

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	describe the process steps required for identification of residents at risk for the development of pressure injuries, identify prevention techniques and interventions to assist with the management of pressure injuries and skin alterations....Skin alterations and pressure injuries are evaluated and documented by the licensed nurse: o Using the Admission or Re-admission Evaluation UDA upon admission or readmission to the facility with a head-to-toe skin evaluation and completion of the Braden Scale For Predicting Pressure Sore Risk UDA. o Using the Braden Scale For Predicting Pressure Sore Risk UDA, weekly X 3 after admission for a total of 4 weekly evaluations, then quarterly. Weekly evaluation of the skin alteration in the resident's medical record by the wound team or licensed nurse per state and federal regulations. Weekly evaluation of the pressure injury in the resident's medical record by the wound team or licensed nurse per state and federal regulations. Stages of a pressure injury: Stage 1 – Non-blanchable erythema of intact skin. Stage 2 – Partial-thickness skin loss with exposed dermis. Stage 3 – Full-thickness skin loss. Stage 4 – Full-thickness skin and tissue loss. Deep Tissue Injury – Persistent non-blanchable deep red, maroon, or purple discoloration. Unstageable – Obscured full-thickness skin and tissue loss. Whenever there is a significant change in condition or clinically indicated....Body audits are completed: By the licensed nurse routinely and documented in the resident's electronic medical record. By the nursing assistant during scheduled baths/showers, and if indicated during routine daily care. The nursing assistant will inform the licensed nurse of any new areas of skin breakdown for evaluation and documentation....Treatment options are			

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	selected based upon the type of wound, tissue type, exudate, condition of the peri-wound, pain, the need for protection of the wound bed, the goal of treatment, and manufacturer’s recommendations for product utilization. Treatments are ordered by the medical practitioner. A complete treatment order consists of the following: Site of application. Type of skin alteration or treatment needed. Cleansing agent, if indicated. Frequency, including end date orders if applicable. Directions for use, if applicable. Primary and secondary dressing, if applicable. Type of securement, if applicable..."			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to prevent two accidents with a mechanical lift and remove a malfunctioning lift from circulation for one Resident (R171) of two residents reviewed for accidents. Findings include:	F0689	**Element 1** Resident #R171 continues to reside within the facility. The resident has been evaluated by therapy services and transfer status updated. **Element 2** Like residents are identified as residents that reside within the facility with transfer status utilizing a mechanical lift. Like residents have had audited to ensure staff or provide a safe transfer with a mechanical lift and the mechanical lifts are functioning. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F689. 2.IDT reviewed the “Transferring Residents Using a Mechanical lift Machine” policy and deemed appropriate. 3.The RN/LPN/ CENA have been re-educated on the Transferring Residents Using a Mechanical lift Machine with emphasis on the preforming a safe transfer and reporting when equipment does not function. 4.The clinical team will complete periodical observations of mechanical lift transfers on	4/2/2026

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	On 3/02/26 at approximately 10:17 a.m., R171 was observed in their room dressed, standing in a standing wheelchair, with a laptop on a tray table. On 3/02/26 at 10:20 a.m., R171 stated, "…Their (lift) machines are not operating well to get me up; their lift machines are broken. Some days I am getting stuck in bed and it started since last Tuesday (2/24/26) and they keep me in bed. I should always have two people to position me. For example, this morning the lift didn't work so they transferred me into the wheelchair with two-person (assistance). The lift would be ideal…" R171 reported their nurse said if they haven't fixed the (Brand name stand) lift by tonight, they were not getting them up (out of bed) tomorrow. R171 said this made them feel anxious and guilty, like they did something wrong. R171 added, "It made me feel helpless." R171 clarified they had to wait longer to get out of bed when this happened. R171 continued, "I wasn't going to report it…" but said it was upsetting them and they did not want to get stuck in bed, because this was not good for their legs as they had a multiple sclerosis (MS) and standing was important to them and they didn't want to get weaker. R171 denied any injury from the sit-to-stand lift not working correctly in the past week however reported they were injured in the lift another time, when staff did not operate the lift correctly. R171 said they wanted to be in bed by 8:30 p.m., however		their units weekly. **Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Director of Nursing / Designee will audit 10 resident's transfers with mechanical lifts per week to ensure the staff are providing a safe transfer and the lift is functioning. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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	sometimes waited one to one and a half hours to be transferred back to bed with the lift problems. On 3/02/26 at 10:25 a.m., R171 described the accident which occurred when staff were transferring them with the facility sit-to-stand mechanical lift a few months before. R171 said their foot became caught under the sit to stand platform during a transfer. R171 said the aide did not move their foot correctly and their foot hit the lift platform and spasmed so hard that their toenail came off. R171 explained this became an open wound and took some time to heal. R171 said they believed the cause was their aide was rushing their care, which occurred sometimes, and was upsetting as they had to deal with an open wound. R171 clarified they felt safest being transferred with the sit-to-stand lift due to their leg weakness, given their MS diagnosis, and this was their preference and was designated for their care. On 3/02/26 at 10:46 a.m., R171 showed Surveyor a paper posted on their bulletin board, which showed R171's transfer status. The post read in handwriting, "…Transfers: x 2 (Name brand) stand (lift)….Toileting: x 1 (Name brand) stand (lift)…" R171 was designated to use the sit-to-stand lift for all transfers per the care note in their room. On 3/02/26 at approximately 3:30 p.m., the floor staff were asked to show the sit-to-stand			

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	lift to this Surveyor. All reported they were unable to locate the sit-to-stand lift, including the unit manager. Review of R171's Care Plan, accessed 3/04/26, revealed R171 required a (Name brand) sit-to-stand mechanical lift or two-person (adapted) assistance for transfers. Review of R171's Minimum Data Set (MDS) assessment, dated 1/05/26, revealed R171 was admitted to the facility on 12/13/24, with diagnoses including multiple sclerosis, depression, and anxiety. The assessment showed R171 required maximal assistance for bed mobility, was dependent for transfers and was frequently incontinent for toileting. R171 was not marked for any behaviors. The assessment showed choices and preferences being honored was very important to R171. Review of the Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R171 was cognitively intact. On 3/02/26 at approximately 3:41 p.m., the Director of Nursing (DON) arrived and acknowledged the sit-to-stand lifts in the building did not work and were removed from circulation on 3/02/26, after they were made aware of the concern. The DON explained R171 had already been reevaluated by physical and occupational therapy, and it was determined they were safe to transfer with two-person assistance until a new sit-to-stand rental lift arrived. The DON explained			

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	that the floor staff and nursing management had not made them aware the sit-to-stand lift in use was not working and was unsafe for residents' use per their own observation. The DON clarified the maintenance staff had confirmed the sit-to-stand lift in use was not functional and had tagged the lift and removed it from use. The DON confirmed there were no accidents or incidents from the lift when it began to malfunction recently. The DON acknowledged they understood the concern and reported at that time they believed no other residents used the sit-to-stand lift, from staff interviews. On 3/02/26 at 4:36 p.m., the Maintenance Director, Staff "I", also reported no staff had brought any concerns about the sit-to-stand mechanical lift to their attention. Staff "I" confirmed they only knew of one sit-to-stand lift in the facility, which the DON confirmed. Both said the lift in the building was unsafe for resident use, and there was no other lift. The DON said the lift was stuck in the wrong position when it was turned "on" and could not be used safely, which Staff "I" confirmed. The DON confirmed they had not received a concern or grievance form related to R171's lift not working either. On 3/02/26 at approximately, 4:40 p.m., Certified Nurse Aide (CNA) "J" was asked how many sit-to-stand lifts were available for resident transfers. CNA "J" reported they only knew of one sit-to-stand life for resident use, however said they had not used it recently.			

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	On 3/02/26 at approximately 4:37 p.m., the sit-to-stand lift was observed with Staff “I” and the DON, with a paper note attached taped to the lift which showed, “Not working”.			
	On 3/02/26 at 4:57 p.m., Physical Therapist (PT) “K” confirmed they had reevaluated R171 on this date, and R171 demonstrated the ability to complete a slide lateral scoot transfer with them, and their technique was safe for staff to complete two-person transfers with R171 until the new sit-to-stand lift was received. PT “K” understood the sit-to-stand lift was not working only on this date and had not been made aware prior.			
	On 3/02/26 at approximately 5:00 p.m., R171 was interviewed with the DON present, and confirmed they had not been injured in the past week when the sit-to-stand lift was not working. R171 described the incident when operator error caused their toe to get caught under the lift, when staff moved the lift too quickly towards them without lifting their foot, resulting in an injury to their toe. R171 reported that incident occurred this summer but did not know of the date. R171 described the lift battery was not always charged and said sometimes the lift did not work as the battery would run out. It was unclear if there was a backup battery, or if this was a malfunction of the lift itself. R171 shared they felt comfortable completing two-person scoot transfers temporarily but said they felt safest in the lift for their daily transfers and for toileting needs.			

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Review of R171’s progress note, dated 8/31/25 at 23:04 (11:04 p.m.), by Licensed Practical Nurse (LPN) “H”, revealed, “Writer was notified by CNA (unnamed) that the resident foot was caught under the sit-to-stand (lift) and that her left great toenail had got caught under it and was bleeding. Upon assessment of the resident toe, writer observed the resident toenail was coming off of her toe. Resident stated that the CNA came into the room with the sit to stand and had pushed it up to her and the CNA had placed one of her feet on the sit-to-stand (lift) and the other one was still on the floor Resident stated that she had ask the CNA if she could open the legs of the sit-to-stand (lift) a little more before trying to move her other foot resident (sic) said that the CNA told her to hold on, she knows what she is doing and that when the CNA tried to move the sit-to-stand (lift) her left foot had started to spasm and her toe had got caught under the bottom of the sit-to-stand (lift) causing her toenail to come off. Writer cleaned the resident toe and contacted the DR (physician). After writer reached out to the DR, he stated to clean the wound with warm water and soap and apply triple antibiotic ointment and wrapped with gauze and kerlix; there was no other bleeding noted after wound care was done. Writer also put in a wound consult and a temporary wound order.”

On 3/04/26 at 12:19 p.m., LPN “H” was asked about the incident with R171 and the sit-to-stand lift when they were assigned to care for R171 on 8/31/25. LPN “H” explained “they

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	were trying to assist the resident getting back into the bed and her foot got caught under the sit-to-stand (lift) and she started to spasm and her foot went up and her toenail got caught…" LPN "H" said they assessed R171 and her toenail was still intact and then her toenail ultimately fell off. LPN "H" said they didn't understand how the incident occurred and they were trying to visualize how the foot could go underneath under the sit to stand. LPN "H" said they believed the aide took R171's foot off the (lift) platform but her foot was caught under platform. LPN "H" concluded R171's foot should not have been under the platform. LPN "H" said, "I keep educating (staff) on the safety of the sit-to-stand. LPN "H" concluded this was an avoidable incident when asked. LPN "H" said they worked with R171 regularly and their foot had healed. LPN "H" said R171 would only transfer with the sit-to-stand lift and declined all other transfers. Review of R171's progress note (after the incident), dated 9/05/25, showed they were seen by wound care for their left great toe, as they had begun to develop cellulitis with an exudated (missing) toenail, which occurred after their injury on the lift. The note showed R171 was in "a lot of pain" however the wound was healing as they were on an antibiotic. The noted further revealed R171 was being followed by both wound care and podiatry closely after the incident. Further review of R171's nursing progress note, dated 9/14/15 at 2:34 (a.m.), revealed another incident with the sit-to-stand lift			

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	during transfers. The progress note revealed, “Writer called to room due to conflict with resident (R171) and CNA (their aide). (R171) stated she needs to have a bowel movement and is constipated and would like to sit on the toilet. CENA (aide) unable to transfer resident at this time due to malfunctioning equipment (lift). Resident (R171) insists on getting up, other options were presented such as bedpan, turning resident on her side, and putting bed in sitting position…” Review of the policy, “Transferring Residents Using a Mechanical Lift Machine”, revised 2/04/26, revealed, “Policy Overview: The purpose of this procedure is to provide guidelines for the safe lifting using a mechanical lifting machine. It is not a substitute for manufacturer’s training or instructions. General guidelines: Follow manufacturers’ guidelines for the number of nursing assistants (or other licensed and trained staff) that are needed to safely move a resident with a mechanical lift. Mechanical lifts may be used for tasks that require: lifting a resident from the floor, transferring a resident from bed to chair (or vice versa), lateral transfers, toileting or bathing, repositioning. Types of lifts that may be available in the facility are: Floor-based full body sling lifts, overhead full body sling lifts, sit-to-stand lifts…Lift design and operation varies across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility…Prepare the environment: Clear an unobstructed path for the mechanical lift, ensure there is enough room to pivot the mechanical lift, position the lift and the surface the resident is transferring from or to			

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	at the correct height. Move the mechanical lift base legs near or around the resident's transferring surface (i.e. bed or wheelchair). Base legs are usually more stable in full open position. Prepare the equipment: Make the battery is charged. Test the lift controls. Ensure the emergency release feature works. Make sure the lift and surface the resident is transferring from and to is stable and locked. Make sure that all necessary equipment (slings, hooks, chains, straps, and supports) are available, appropriate, and correctly sized. Examine sling and attachment areas for tears, holes, and frayed seams. Do not use sling with any signs of wear…Perform Safety Check: Before the resident is lifted, double check the security by examining that all hooks, clips, fasteners, and sling straps are securely fastened and will not unhook during use			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was	F0690	**Element 1** Resident #R214 no longer resides within the facility. **Element 2** Like residents are identified as residents that reside within the facility with suprapubic urinary catheters. Like residents have been audited to ensure physician orders for catheter care and nursing assessments. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F690. 2.IDT reviewed the "Catheter Care" policy and deemed appropriate. 3.IDT reviewed the "Physician and Practitioner Orders" policy and deemed appropriate.	4/2/2026

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	necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: This citation pertains to intake 2745432. Based on observation, interview and record review, the facility failed to implement timely care and monitoring of a resident's suprapubic urinary catheter (flexible tube surgically inserted into the bladder through the skin of the abdominal wall) which included physician orders and nursing assessment for one (R214) of four residents reviewed for urinary catheters. Findings include: Review of a complaint reported to the State Agency (SA) included allegations that the facility was not properly caring for a resident with a urinary catheter. On 3/2/26 at 11:35 AM, R214 was observed		4.The RN/LPN have been re-educated on the catheter care and physician order policies with emphasis on completing nursing assessments and timely implementation of physician orders for catheter care. 5.The clinical team will monitor newly admitted resident with catheters to ensure orders and assessments are completed during morning clinical meetings. **Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Director of Nursing / Designee will audit 5 residents with catheters to ensure physician orders are implemented and nursing assessments are completed. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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	in their room and a urinary catheter drainage bag was observed secured to the side of the bed and the urine appeared very dark. At that time, R214 reported there was blood in their urine and they were upset about the catheter site hurting and just wanted it out. On 3/4/26 at 10:20 AM, R214 was observed in their room, seated in a wheelchair. When asked about what the facility had done to follow up on their concerns from 3/2/26, R214 reported they were due to go to a urology appointment today because they were told the facility staff were not able to change the suprapubic tubing and now, they had to see a urologist. The resident further reported they really didn't want to go out to see them and asked why they couldn't do that here. When asked if the nursing staff had assessed their urine output since their admission, they reported no. R214 reported they've had the suprapubic for about six months and was recently on antibiotics for Urinary Tract Infection (UTI) at the hospital and was worried because it hurt so much about every 45 minutes or so. Review of the clinical record revealed R214 was admitted into the facility on 2/26/26 with diagnoses that included: other fracture of left femur, other nondisplaced fracture of upper end of left humerus, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus with diabetic nephropathy, kidney transplant status, end stage renal disease, and other neuromuscular dysfunction of bladder. There was no Minimum Data Set (MDS) assessment to review at this time due to the resident’s new admission status.			

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	Review of the physician orders since admission revealed there were no orders for the care, monitoring, or assessment of the resident’s suprapubic catheter. Additionally, review of the medication and treatment administration records revealed there was no documentation of any monitoring or care for R214’s suprapubic urinary catheter. Review of the care plans included: "Use of indwelling urinary catheter needed due to Neurogenic bladder". This care plan and interventions were initiated on 2/27/26 and as of this review (3/3/26) there were no new interventions added since. Interventions included: "Catheter Care". (There were no specific details identified.) "Change catheter per physician's order". (There was no physician’s order.) "Change urinary collection bag as needed". (There was no documentation this was completed in the electronic medical records/EMR since admission.) "Maintain drainage bag below bladder level". "Report any changes in amount and color, or odor of urine". "Report to physician signs of UTI such as blood, cloudy urine, fever, increased restlessness, lethargy, c/o (complaints of) pain/burning, acute change in mental status, functional decline in ADLs (Activities of Daily			

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Living)".

"Resident requires enhanced barrier precautions related to: Foley". This was initiated on 2/27/26 and was incomplete. There was no identification of the specific urinary catheter utilized by R214.

Review of R214's hospital documentation prior to admission included:

"...Has hx (history) of suprapubic catheter which is currently plugged as he is trying to be weaned off of it...Patient is a 57 year old male with hx of ESRD (End Stage Renal Disease) now s/p (status post) renal transplant in 5/2025, chronic urinary retention due to neurogenic bladder from basal ganglion stroke s/p (status post) suprapubic catheter placement in October 2025...Urology consulted for SP tube management and hematuria in SP tube 2/23/2026: 20 Fr (French) SP tube exchanged without difficulty...SP tube exchanged today without incident. He reports burning has resolved...Hematuria has resolved..."

Review of the nursing admission evaluation dated 2/26/26 documentation revealed there was no identification of the specific suprapubic urinary catheter and read, in part: "...Urinary Characteristics...Amber...External catheter (condom catheter…)...b. Yes...Indwelling Catheter Care Plan..."

Review of the progress notes included several entries of R214's complaints of pain and discomfort with the suprapubic catheter since 2/27/26, but did not include any specific orders for the care of and monitoring of the suprapubic catheter until it was

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identified as a concern during the survey. As of 3/2/26 approximately 5:00 PM, there was no evidence of any provider evaluation of R214’s catheter site.

Documentation of the progress notes included:

An entry on 2/27/26 at 5:30 AM by Nurse ‘M’ read, “Resident arrived to facility on 2/26/26 at approximately 2230,from [name of local hospital].Resident AOX4 (alert and oriented to person, place, time and situation) able to make needs Known…Resident is diabetic, with indwelling foley catheter…” This assessment did not identify R214’s use of a suprapubic urinary catheter, or identify need for specific orders to provide care.

An entry on 2/27/26 at 6:42 PM by Nurse ‘P’ read, “Change Foley Catheter Catheter [sic] Size/French: (left blank) Balloon CC (Cubic Centimeters): (left blank) one time only for Hematuria until 02/27/2026 23:59 unable to change due to being suprapubic catheter.”

An entry on 2/27/26 at 6:47 PM by Nurse ‘P‘ read, “Writer unable to administer new foley due to catheter being a suprapubic catheter. Physician informed of situation. Per physician orders bedtime dose of enoxaparin and morning aspirin chewable placed on hold for hematuria.”

An entry on 2/28/26 at 12:03 PM read, “Patient alert and verbal able to make needs known. Patient verbalized he was told a couple days ago that he will have an appointment to have his suprapubic catheter changed today and will be transported by stretcher to [name of local hospital]. No order listed and no paperwork available about any

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	appointment. Observed dark yellow blood-tinged urine in foley bag, also observed urine in brief. Patient complains of burning while urinating. (Nurse Practitioner/NP ‘N’) on call for (Physician) notified and made aware, noted new order for UA C&S (Urinalysis with Culture and Sensitivity),Pyridium Oral Tablet 100 MG (Milligrams) Give 1 tablet by mouth three times a day for Dysuria (pain, discomfort, or burning sensation during urination) for 2 Days…”. There was no orders implemented for the monitoring and/or care of the suprapubic catheter. As of 3/2/26, there was no further documentation available in the EMR for review that nursing staff and providers had assessed/evaluated the resident’s urinary catheter status, including any urine output. On 3/3/26 at 10:33 AM, an interview was conducted with R214’s Nurse (Nurse ‘Q’). When asked about R214’s suprapubic catheter and whether they had assessed that yet today, or if they could give any additional information, Nurse ‘Q’ reported they hadn’t been down this hallway in a while and further reported R214 had an appointment for the catheter today but they were not sure what was going on with it and acknowledged they did see the redness in the tubing. When asked if they assessed the suprapubic catheter site, or urine output, Nurse ‘Q’ reported they don’t typically deal with suprapubic catheters but orders should be in the TAR (Treatment Administration Record) and he said he has the appointment. At that time, Nurse ‘Q’ was asked to review the EMR and confirmed there were no orders for R214’s suprapubic catheter. Nurse ‘Q’ further reported there should be an order to			

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monitor output but confirmed there was not.

On 3/3/26 at 10:37 AM, an interview was conducted with Nurse Manager (NM 'R') who reported they had been in that role since April 2025. When asked about the facility's process for implementing care for residents that were admitted with indwelling urinary catheters, NM 'R' reported when residents came into the facility, either they or the other NM review the record the next morning. NM 'R' further reported that was a second check to see if the nurse missed something and if residents came after hours, they would review it the next morning. NM 'R' reported R214's day after admission was on 2/27 and they were not available and acknowledged that got missed. NM 'R' further reported they were not able to see that any practitioners had assessed R214 to address the suprapubic catheter but had given orders for a urine test and medication to help with the burning. NM 'R' reviewed the urine results and reported they were negative for an infection. When asked about the nursing documentation of any assessment monitoring following the initial complaints of burning and pain, NM 'R' reported there should have been ongoing evaluation by the nurses and confirmed that was not documented in the EMR.

When asked about if there should be specific orders for the care and monitoring of suprapubic urinary catheters, NM 'R' reported yes that should've been put on at the time of admission and was missed by multiple nurses.

Further review of the clinical record revealed orders for the suprapubic catheter were not implemented until after the discussion with

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NM ‘R’. Additionally, an entry created on 3/3/26 at 11:49 AM for effective date 3/2/26 at 12:48 PM (four days after complaints were voiced by R214) by NP ‘S’ documented, in part:

"...The pt (patient) was seen and examined, sitting up in bed, reports he is uncomfortable due to burning at the catheter site…D/w (Discussed with) staff and nurse plan of care and need for f/u (follow up) appts (appointments)...Medication List...Methenamine Hippurate Oral Tablet 1 GM (Gram) Give 1 tablet by mouth one time a day for Antibiotic until 03/20/2026 08:59...Neurogenic bladder SP catheter exchange q32 (every) weeks and as needed Requested f/u (follow up) appt with urology..."

According to the facility's policy titled, "Catheter Care" dated 2/2/2026:

"...It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use...Catheter care will be performed every shift and as needed by nursing personnel...Observe the resident for complications associated with urinary catheters. Report unusual findings to the nurse supervisor (or if nurse to the physician)...if the resident indicates that his or her bladder is full or that he or she needs to void (urinate)...if urine has an unusual appearance (i.e., color, blood, etc.)...in the event of bleeding, or if the catheter is accidently removed...if the resident complains of burning, tenderness, or pain in the urethral area...if signs and symptoms of urinary tract infection or urinary retention occur..."

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	235556	A. BUILDING ______ B. WING ______	**3/4/2026**

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	According to the facility's policy titled, "Physician and Practitioner Orders" dated 2/3/2026: "...Admission Orders will be obtained for the residents' immediate care and needs. The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission and will include at a minimum: An order for the resident to be admitted to the facility...Routine care orders...The licensed nurse is responsible for physician notification per physician parameters for a resident's refusal of medications, treatments, and cares..."			
F0694 SS= D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate PICC line (Peripherally Inserted Central Catheter) care was provided for one resident (R197) of one resident reviewed for Parenteral/IV fluids. Findings include: On 3/2/2026 at approximately 9:44 a.m.,	F0694	**Element 1** Resident #R197 no longer resides within the facility. **Element 2** Like residents are identified as residents that reside within the facility with Peripherally inserted central catheter (PICC) lines. Like residents have been audited to ensure PICC line care was provided and documented per physician orders. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F694. 2.IDT reviewed the “Physician and Practitioner Orders” policy and deemed appropriate. 3.The RN/LPN have been re-educated on the physician order policies with emphasis on he licensed nurse is responsible for administering medications,	4/2/2026

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	R197 was observed in their room, lying in their bed. R197 was observed to have a PICC line in their upper right arm with the dressing dated 2/25/26 (Wednesday). R197 was queried if Nursing staff are changing and assessing the dressing and they indicated that it needed to be changed. At that time, the med tape securing the dressing to the arm was observed to be losing its adhesiveness. On 3/3/26 at approximately 11:06 a.m., R197 was observed in their room, lying in their bed. R197 was observed to have a PICC line in their upper right arm with the dressing dated 2/25/26 and the tape holding the dressing to be coming apart. On 3/3/26 at approximately 11:38 a.m., R197's PICC line dressing was observed with Nurse Manager "R" (NM "R") and verified that the date on the dressing was 2/25/26. At approximately 11:40 a.m., the TAR (treatment administration record) for March 2026 was reviewed with NM "R" and it was observed that R197 was documentation in the TAR as having had the dressing change completed on 3/1/26. NM "R" indicated they would have to talk with the Nurse regarding appropriate documentation on treatments that were not completed. On 3/2/26 the medical record for R197 was reviewed and revealed the following: R197 was initially admitted to the facility on 1/31/26 and had diagnoses including Infection and Inflammatory reaction due to due to internal right knee prosthesis. A review of R197's carelans revealed the following: "Focus-•Potential for complications at IV (intravenous) insertion site. PICC		administering/applying/completing treatments and completing cares per physician orders. 4.The clinical team will randomly audit their residents with PICC lines to ensure the dressings are being completed weekly. **Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Director of Nursing / Designee will audit 5 residents with PICC line to ensure dressings changes are occurring and documented. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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	inserted at right arm. Date Initiated: 01/31/2026...Interventions-Dressing change by physician order and prn if soiled or wet. Date Initiated: 01/31/2026..." A Physician's order dated 1/31/26 revealed the following: "Change PICC Line Dressing (location): RUE (right upper extremity) every day shift every Sun (Sunday) for safety monitoring AND as needed for safety monitoring" On 3/3/26 at approximately 11:51 a.m., the Director of Nursing (DON) was informed of the Physician's order that indicated it should have been done every Sunday, according to the Physician's order with the last change scheduled have been done on (3/1/26) and they reported that it should have been done that Sunday and would have to address the issue of documentation error with the Nurse who documented the treatment had been completed when it had not.			
F0761 SS= E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761	**Element 1** Items observed in the medication cart 100, 200, and 600 were immediately disposed of. **Element 2** Medication carts located within the facility were audited to ensure they are free of loose pills and unlabeled items. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F761.	4/2/2026

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§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is NOT MET as evidenced by:

Based on observation and interview, the facility failed to ensure the storage of medications were labeled with name of medication and resident specific identifiers in three of five medication carts reviewed for medication storage.

Findings Include:

On 3/3/26 at 8:36 AM, the 600-hallway medication cart was observed for medication storage with Registered Nurse (RN) “C” and the Director of Nursing (DON) and revealed on the bottom of drawer two, nine loose medications and bottom of drawer three observed two medications loose with no medication or patient identifiers. Five vials of albuterol (medication for breathing treatments) were observed lying on base of drawer with no patient identifiers. RN “C” and

2.IDT reviewed the “Medication and Treatment Storage” policy and deemed appropriate.
3.The RN/LPN have been re-educated on the medication and treatment storage policy with emphasis on labeling and dating of medications and treatments for safe administration and safe and secure storage.
4.The clinical team will randomly audit medications carts to ensure no loose pills and unlabeled items are identified weekly.

Element 4
The process to ensure that the specific citation remains corrected includes:
1.The Director of Nursing / Designee will audit 5 medication carts to ensure there are no loose pills and items are dated / labeled correctly. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed.
2.The Administrator will be responsible for sustained compliance.

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the DON acknowledged loose medications are not proper storage in the medication cart and disposed per protocol.

On 3/3/26 at 9:05 AM, the 100-hallway medication cart was observed for medication storage with Licensed Practical Nurse (LPN) “B” and revealed on the bottom of drawer two, four unidentifiable medications and no resident identifiers and drawer three was observed with four unidentifiable medications and no resident identifiers. LPN “B” acknowledged the loose medications and commented they would dispose of them.

On 3/3/26 at 9:55 AM, the 200-hallway medication cart was observed for medication storage with LPN “E” and revealed the bottom of drawer two, nine unidentifiable medications and no resident identifiers. The last bottom drawer had one vial of an unknown medication, stated by LPN “E” it was a respiratory medication and had no resident identifier.

On 3/3/26, the DON was informed observations detected on the 600-hallway medication cart had similar findings on the 100 and 200 medications carts.

Review of the facility policy titled Medication and Treatment Storage dated 2/3/2026 documented:

“It is the policy of this facility to ensure accurate labeling and dating of medications and treatments for safe administration and safe and secure storage…”

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F0770 SS= D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure Physician ordered laboratory diagnostics (labs) were completed and reported to the Physician in a timely manner for one resident (R52) of one resident reviewed for laboratory diagnostics. Findings include: On 3/2/26 the medical record for R52 was reviewed and revealed the following: R52 was initially admitted to the facility on 2/20/26 and had diagnoses including Pneumonia and Sepsis. A Physician's order dated 2/20/26 revealed the following: "CBC (complete blood count) and CMP (comprehensive metabolic panel) Dx (diagnosis): New Admit" A review of R52's laboratory results in the electronic medical record did not reveal any lab results for R52's labs ordered on 2/20/26. On 3/4/26 at approximately 11:54 a.m.,	F0770	**Element 1** Resident # R52 continues to reside within the facility. The resident received lab testing on 3/2/26. Results were reviewed with the physician services. **Element 2** Like residents are identified as residents that reside within the facility with orders for lab services. Like residents were audited to ensure labs have been completed per physician orders. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F770. 2.IDT reviewed the “Laboratory Results” policy and deemed appropriate. 3.The RN/LPN were re-educated on the Laboratory policy with emphasis ensuring lab sheets are being completed. 4.The facility reviewed the scheduled lab draw days with the lab services. 5.A Lab tracking log was created and placed in the lab service binder. Nursing Managers to review the tracking log for completion of labs. **Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Director of Nursing / Designee will audit 5 residents’ physician orders for lab services to ensure labs had resulted and reported. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for	4/2/2026

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	Nurse Manger "R" (NM "R") was queried regarding the lab results for 2/20/26. NM " R" reported that new admission residents have baseline labs ordered and drawn upon admission, and that they would check for the results. On 3/4/26 at approximately 12:02 p.m., NM "R" reported the facility did not have the results from the labs ordered on 2/20/26 because they were never drawn, because the Nurse who completed R52's admission orders failed to place the request in the laboratory book for lab technician to complete the order. NM "R" reported the facility had to recently reorder the labs to get some baseline results. A review of R52's lab results from the re-order of labs that was completed on 3/2/25 revealed R52 had multiple values that were indicated to be outside of normal reference ranges. On 3/4/26 at approximately 1:31 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the expectation of Physician ordered labs to be completed, and they indicated it should be competed when the order is received. On 3/4/26 a facility document titled "Laboratory Results" was reviewed and revealed the following: "Policy Overview-The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law...The facility must provide or obtain laboratory services to meet the needs of its residents. The facility will assist the resident in making transportation arrangements to		sustained compliance.	

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	and from the laboratory if necessary. Labs not drawn as ordered are reported to the attending physician for further direction. • STAT lab results are received according to timeframes established in the contract. Laboratory results will be dated and contain the name and address of the testing laboratory...The staff will process test requisitions and arrange for tests. The laboratory or other testing source will report test results to the facility. The laboratory will notify the facility of critical or panic laboratory results. The laboratory will notify the facility of stat laboratory results. For facilities and laboratories integrated with the electronic health record..., laboratory results will display in [EMR] under the resident's results tab, and unreviewed laboratory results can also be accessed under the Clinical Dashboard and under the Clinical Lab/Rx Results Dashboard in [EMR]. For facilities and laboratories not integrated with electronic health record [EMR], laboratory results may be faxed to the facility or retrieved from the laboratory's website. Those results will be uploaded into the resident's electronic health record. Laboratory results will be classified as "Critical/Panic", "Abnormal", or "Normal", according to the lab parameters. Critical or Panic and Abnormal laboratory result notifications: Promptly notify physician or physician extender with lab result and resident current condition. If results are integrated with [EMR], click "Mark as Reviewed" on the laboratory result and document response and any new orders as applicable. If results are not integrated with [EMR], document notification, response, and any new orders as applicable. Notify and document notifications to resident or resident representative, as applicable. Implement new orders, as applicable. If the physician fails to			

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	respond to the Critical or Panic laboratory results within 2 hours, place another call to the physician and/or the Medical Director..." No laboratory diagnostics results for the lab diagnostics ordered on 2/20/26 were provided for review by the end of the survey.			
F0880 SS= D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies,	F0880	**Element 1** No residents were affected due to this deficient practice. **Element 2** Like residents are identified as residents that reside within the facility. The infection control mapping was reviewed to ensure that there was no spread of infection via hand contact. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F880 2.IDT reviewed the “Hand Hygiene” Policy and deemed it appropriate. 3.The RN/LPN was re-educated on the hand hygiene policy with emphasis on hand hygiene during medication administration. **Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Director of Nursing / Designee will audit 10 Nurses per week to ensure appropriate hand hygiene is occurring during medication administration. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be	4/2/2026

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	and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of		reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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its IPCP and update their program, as necessary.

This REQUIREMENT is NOT MET as evidenced by:

Based on observation and interview, the facility failed to provide proper hand hygiene procedures during medication administration for three (R128, R53, R215) residents of four reviewed for medication administration.

Findings include:

On 3/3/26 at 8:12 AM, a medication administration observation was conducted with Registered Nurse (RN) “C” for R128. RN “C” donned a pair of clear gloves at the 600-hallway cart without cleaning their hands. RN “C” proceeded to touch items on top of cart including a stack of clear plastic cups, poured a brown liquid supplement into a plastic cup, retrieved a pen from the top of cart, and opened the top drawer, donned with the same gloves, RN “C” proceeded to remove the medicine cup of opened medications and liquid supplement for R128 and proceeded to administer at bedside.

On 3/3/26 at 8:58 AM, a medication administration observation was conducted with Licensed Practical Nurse (LPN) “B” for R53 and was observed not performing hand hygiene prior to medication preparation and not performing hand hygiene prior to medication administration to R53.

On 3/3/26 at 9:09 AM, a medication administration observation was conducted with LPN “B” for R215 and was observed in front of the room not performing hand

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	hygiene prior to donning Personal Protective Equipment (PPE). LPN “B” proceeded to walk back to the cart, touch the prepared medications, open the door to the room, move the bedside side table and proceeded to administer the medications to R215. Review of the facility titled Hand Hygiene dated 4/14/2023 documented. “…guidelines to staff for proper hand hygiene techniques that will aid in the prevention and transmission of infection…Included but not limited to: Before applying and after removing personal protective equipment (PPE), including gloves…Before preparing or handling medications…”			
F0921 SS= E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain general cleanliness and repair of a cabinet surface, laundry equipment, and plumbing fixture resulting in an increased potential for contamination affecting all residents. Findings include:	F0921	**Element 1** No residents were affected due to this deficient practice. **Element 2** The soiled linen carts have been replaced and cleaned. The Cranbrook pantry floor under the sinks have been repaired and cleaned. The air gap on the Hunter unit has been repaired. **Element 3** The procedure to implement the plan of correction included: 1.IDT reviewed F921 2.The Maintenance Director re-educated on the repairing and maintaining broken items. 3.The Advocate Team will assist with items needing repairs daily during rounds and report to Maintenance.	4/2/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235556	A. BUILDING ______ B. WING ______	**3/4/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodward Hills Health and Rehabilitation Center	**39312 Woodward Ave Bloomfield Hills, MI 48304**

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	On 03/02/2026 at 10:10 AM in the laundry soiled linen room observed 2 plastic carts for transport of soiled linens that had debris and soil (used gloves, food wrappers, sticky brown substance) covering the interior bottom of the carts beneath the false fabric bottom. The same 2 carts were cracked and not smooth and easily cleanable around the top perimeter. The metal attachments (attached near the 4 corners of each bin) for the false bottom were worn and difficult to remove for cleaning of the bin and had worn to have sharp edges. During this observation when staff "L" was asked about these carts he said that some new carts had been purchased and were in use for clean linen transport and that more were needed. He indicated that the expectation was that the carts were cleaned daily at the end of the shift. On 03/02/2026 at 2:50 PM observed in 1st floor Cranbrook pantry room that the floor of the cabinet under the sink was water damaged and the surface was peeling and no longer smooth and cleanable. During the observation when interviewed about the damaged surface, staff "I" said he was not aware of this and would add it to the task list. On 03/02/2026 at 2:55 PM observed in 2nd floor Hunter pantry room that the drain tubing from the ice bin was submerged below the rim of the drain line and not properly protected with an air gap. During the observation when interviewed about the required air gap, staff "I" said he was not aware of this and will make the needed adjustment to the drain line.		**Element 4** The process to ensure that the specific citation remains corrected includes: 1.The Administrator / Designee will audit air gaps, linen carts, and pantry floors under sinks weekly to ensure items are in good repair and clean. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed. 2.The Administrator will be responsible for sustained compliance.	

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