STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Manor Healthcare Center	730 Kimole Lane Adrian, MI 49221

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to limit the duration of a PRN (as needed) psychotropic medication to 14 days and/or ensure the physician documented rationale to extend the duration of use for one (Resident #2) out of five reviewed for unnecessary medications. Findings include: Resident #2. (R2) Review of the medical record reflected R2 was an initial admission to the facility on [DATE] and admitted to hospice on 05/16/2025. Diagnoses of Chronic Obstructive Pulmonary Disease, Diabetes, Acute Kidney Failure, Chronic Kidney Disease, Stroke and unsteadiness on feet. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2025 revealed R2 had a Brief Interview of Mental Status (BIMS) of 11 (moderately impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R2 is dependent with all care and uses an electric wheelchair as an assistive device. Record revealed R2 had Ativan oral tablet 0.5mg, give 1 tablet by mouth every 4 hours as needed for anxiety, start date of 05/16/2025 with no end date. Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, shortness of breath, start date of 05/16/2025 with no end date. Hydrocodone/acetaminophen oral tablet 5/325mg, take one tablet by mouth every 6 hours as needed for pain, maximum daily amount 4 tablets a day, start date of 04/27/2025 with no end date. Record review of the Medication Administration Record (MAR) for the month of May 2025 showed R2 did not receive any Ativan 0.5mg tablets. R2 requested Hydrocodone 5/325mg tablet three times for a pain rated 5-7 on a scale of 0-10. R2 did not request any Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, or shortness of breath. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MAR for the month of June 2025 showed R2 did not receive any Ativan 0.5mg tablets. R2 requested Hydrocodone 5/325mg tablet three times for a pain rated 5-7 on a scale of 0-10. R2 did not request any Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, or shortness of breath. During an interview on 06/04/2025 at 8:21AM, SWD C stated his role is to get the consents for the use of these medications and nursing is the one who addresses them. SWD C added they do not like prn's, they do a 14-day trial and see how often they use it, they try to use non-pharmacal first. During an interview on 06/04/25 at 8:37 AM, DON B stated there would be a 14 day stop date and provider had to write a note. Hydrocodone/acetaminophen oral tablet 5/325mg, take one tablet by mouth every 6 hours as needed for pain, maximum daily amount 4 tablets a day, start date of 04/27/2025 with no end date. DON B added providers just leave that as needed, if pharmacy had not caught it, they usually do. Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, shortness of breath, start date of 05/16/2025 was ordered from hospice and Hydrocodone/acetaminophen oral tablet 5/325mg, take one tablet by mouth every 6 hours as needed for pain, maximum daily amount 4 tablets a day, start date of 04/27/2025 was ordered prior. DON B stated they would not stop the as needed medications or give an end date. These as needed orders were written by DON B. Per the State Operation Manual (SOM) . PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication . Record review of all discipline progress notes revealed no pain or anxiety re- assessments following the addition of Hydrocodone/acetaminophen oral tablet 5/325mg, take one tablet by mouth every 6 hours as needed for pain, maximum daily amount 4 tablets a day, start date of 04/27/2025, Ativan oral tablet 0.5mg, give 1 tablet by mouth every 4 hours as needed for anxiety, start date of 05/16/2025 with no end date. Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, shortness of breath, start date of 05/16/2025, within the 14 days following the starting of these medications as recommended by the SOM. There was no documentation that these medications were still needed or not.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure two (Resident #18 and Resident #2) residents reviewed for care plans, had a comprehensive care plan that was revised for resident care needs, resulting in the potential for all care needs not being met. Findings Include: Resident # 18 (R18) Review of the medical record reflected R18 was an initial admission to the facility on [DATE] and readmitted after a hospital stay on 03/24/2023. Diagnoses of heart failure, Dysphagia (difficulty swallowing), Aphasia (difficulty communicating due to stroke), muscle weakness, abnormal gait and a history of a stroke. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2025 revealed R18 had a Brief Interview of Mental Status (BIMS) of 13 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R18 requires assistance with personal care and uses a wheelchair as an assistive device. During an interview on 06/03/25 at 12:03 PM, R18 could answer questions by nodding her head or pointing to the item. Writer asked R18 if she was a smoker, and she nodded her head yes. Writer asked where she kept her cigarettes and lighter, she pointed to her top drawer, writer asked permission to open the drawer, and she nodded her head yes. No cigarettes or lighter visible in her drawer. Writer asked if her if she had to keep her cigs and lighter locked up, she nodded her head yes and pointed out in the hallway, writer asked her if she kept them in the medication cart and she nodded her head yes. During an interview on 06/03/25 at 12:07 PM, DON B stated all the smoking residents keep their cigarettes, lighters, and vape devices in their rooms. DON B stated they did a smoking assessment and determined if they could smoke independently or not and if so, they could keep their supplies in their room. DON B also stated the residents could store smoking supplies in their rooms as it is their property. Record review revealed R18 had a previous smoking assessment dated [DATE], it was a smoking agreement that was signed by R18. R18 was no longer able to smoke independently as documented on her smoking letter dated 06/25/24 and signed by LNA A. This smoking document stated R18 was non-compliant with the smoking agreement, so her smoking devices needed to be always locked up with the nursing staff. This same document had the date crossed out and dated 06/25 with staff initials. During an interview on 06/03/25 at 3:54 PM, Licensed Practical Nurse (LPN) F stated R18 had her cigarettes and lighter in her room. LPN F also stated she could keep them with her in her room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/04/25 at 12:13 PM, DON B stated only the smokers got the smoking assessment. Shows how often they smoke, what they smoke, care planned yes/no, and if nursing staff had to keep items locked up. DON B also stated they look at how they light it, do they need assistance, can they smoke on their own, can they put out the cigarette themselves. DON B also stated the smoking assessment form shows dependent or independent outside in the courtyard. DON B stated residents with supervised smoking is someone who needs assistance with lighting the cigarette, holding of the cigarette, and they would have certain smoking times. DON B stated they currently do not have anyone that needs help/supervising while smoking. DON B stated residents smoking unsupervised, means they can smoke when they want to, could go in and out of the courtyard as they want to, no set times. DON B added there is no need for any staff to be out there with them because of their smoking agreement. They can keep their own smoking parafunctional in their room in their possession. DON B stated they look at residents Brief Interview for Mental Health (BIMBS) score so if they are over a 11-12 and above can keep items in their smoking paraphernalia in their room. Writer asked if she had any concern with fire risk at the bedside, DON B stated no. Writer asked if the smoking paraphernalia was secured in their room? DON B stated no, it is in their room or in their pockets. Writer asked DON B how she assured other residents did not get a hold of these. DON B stated they had not had that problem before. Writer asked DON B if she was aware the smoking residents were leaving their paraphernalia sitting out on the over the bed table. DON B stated she was not aware of any residents leaving their smoking items out in the open. Writer asked DON B if R18 was a supervised smoker, due to the smoking letter that stated she was non-compliant and no longer allowed to smoke independently. DON B stated this resident was an independent and could keep her smoking items in her room. Writer asked DON B why R18 had a smoking agreement that documented that she was non-complaint with the smoking agreement and was now supervised as of 06/24,2024 and that date is crossed out with 06/25 written through it and it was initialed. DON B stated R18 was independent, and she was unaware of the letter stating she was no longer independent. Care plan initially included: *Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Date Initiated: 09/16/2021 Revision on: 02/18/2024. o Instruct resident about the facility policy on smoking: locations, times, safety concerns. Date Initiated: 09/16/2021. Revision on: 02/07/2024. o Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Date Initiated: 09/16/2021. Revision on: 12/02/2022 o Observe clothing and skin for signs of cigarette burns. Date Initiated: 09/16/2021. Revision on: 12/02/2022 o The resident's smoking supplies are stored are with her. Date Initiated: 04/14/2023 Revision on: 06/02/2025 (during this survey) The resident can smoke: Timed smoker. Date Initiated: 09/16/2021. Revision on: 07/10/2024 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed R18 had her independence of smoking unsupervised taken away on 04/24/2024, however the care plan was not updated to reflect she needed supervision with smoking and all her smoking parafunctional was to be locked up with nursing staff. Record review also noted that R18 was allowed to smoke unsupervised after deeming her unsafe to do so. Her care plan was not updated or revise to maintain her safest as well as others. Resident #2 (R2) Review of the medical record reflected R2 was an initial admission to the facility on [DATE] and admitted to hospice on 05/16/2025. Diagnoses of Chronic Obstructive Pulmonary Disease, Diabetes, Acute Kidney Failure, Chronic Kidney Disease, Stroke and unsteadiness on feet. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2025 revealed R2 had a Brief Interview of Mental Status (BIMS) of 11 (moderately impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R2 is dependent with all care and uses an electric wheelchair as an assistive device. Record review revealed R2 was admitted to hospice on 05/16/25 with Hospice Agency. admission paperwork was under the miscellaneous tab, with minimal information included. Record review revealed there was minimal coordination of care between facility and hospice team upon admission on ly. Facilities care plan did not include hospice services. There was no comprehensive care plan for hospice. There was no visit notes uploaded in the Electronic Medical Record (EMR). No filled in calendar to reflect on which days the hospice staff would be making visits, nor did it reflect what care the hospice Certified Nursing Assistant (CNA) would provide above and beyond what the facility CNA would be providing. Record review of the hospice binders behind the nurse's station on hall 200, there was no hospice binder for R2 to aid in the facility staff knowing when the disciplines were coming to the facility and what services they would be providing above and beyond what services the facility was providing. Also missing a comprehensive care plan. During an interview on 06/04/25 at 8:18 AM, Social Work Director (SWD) C stated that after checking with the Director of Nursing (DON) B the hospice notes are in the EMR under the miscellaneous tab. During an interview on 06/04/25 at 8:36 AM, DON B stated some of the hospice documents were under the miscellaneous tab in the EMR. DON B stated if we (surveyors) were not there, she would have uploaded these documents into EMR. Record review revealed no hospice comprehensive care plan had been uploaded into the EMR under the miscellaneous tab as stated by DON B.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper communication/documentation of Hospice services provided to two (Resident #42 and Resident R2) of two resident reviewed for Hospice services, and the facility failed to follow physician orders and properly complete catheter care for one resident (Resident #38) of three residents reviewed for quality of care. Findings include: Resident #42 (R42) Review of the medical record reflected R42 was an initial admission to the facility on [DATE] and admitted to hospice on 03/26/2025. Diagnoses of Neurocognitive Disorder with Lewy Bodies, Dementia, Osteoarthritis, Stroke, Depression and Anxiety. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/28/2025 revealed R42 had a Brief Interview of Mental Status (BIMS) of 02 (severe impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R42 requires assistance with personal care and uses a walker or wheelchair as an assistive device. Record review revealed there was no coordination of care between facility and hospice team. Facilities care plan was not updated to include hospice services. There was no visit notes uploaded in the Electronic Medical Record (EMR). No calendar to reflect on which days the hospice staff would be making visits, nor did it reflect what care the hospice Certified Nursing Assistant (CNA) would provide above and beyond what the facility CNA would be providing. Record review of the hospice binder behind the nurse's station on hall 200, contained the admission paperwork, blank monthly calendars, no care plan for disciplines. No medication list, no coordination of care provided on the facility care plan. During an interview on 06/04/25 at 8:18 AM, Social Work Director (SWD) C stated that after checking with the Director of Nursing (DON) B the hospice notes are in the EMR under the miscellaneous tab. During an interview on 06/04/25 at 8:36 AM, DON B stated some of the hospice documents were under the miscellaneous tab and hospice nurse's notes could document in EMR. DON B stated if we/surveyors were not there, she would have uploaded these documents into EMR. Record review revealed no hospice documentation was uploaded into the EMR under the miscellaneous tab as stated by DON B. Resident #2 (R2) Review of the medical record reflected R2 was an initial admission to the facility on [DATE] and admitted to hospice on 05/16/2025. Diagnoses of Chronic Obstructive Pulmonary Disease, Diabetes, Acute Kidney Failure, Chronic Kidney Disease, Stroke and unsteadiness on feet. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2025 revealed R2 had a Brief Interview of Mental Status (BIMS) of 11 (moderately impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R2 is dependent with all care and uses an electric wheelchair as an assistive device. Record review revealed R2 was admitted to hospice on 05/16/25 with Hospice Agency. admission paperwork was under the miscellaneous tab, with minimal information included. Record review revealed there was minimal coordination of care between facility and hospice team. Facilities care plan was no updated to include hospice services. There was no visit notes uploaded in the Electronic Medical Record (EMR). No filled in calendar to reflect on which days the hospice staff would be making visits, nor did it reflect what care the hospice Certified Nursing Assistant (CNA) would provide above and beyond what the facility CNA would be providing. Record review of the hospice binders behind the nurse's station on hall 200, there was no hospice binder for R2 to aid in the facility staff knowing when the disciplines were coming to the facility and what services they would be providing above and beyond what services the facility was providing. Also missing was a care plan, visit notes, medication list, coordination documents and a copy of the signed admission certification period document. During an interview on 06/04/25 at 8:18 AM, Social Work Director (SWD) C stated that after checking with the Director of Nursing (DON) B the hospice notes are in the EMR under the miscellaneous tab. During an interview on 06/04/25 at 8:36 AM, DON B stated some of the hospice documents were under the miscellaneous tab and hospice nurse's could document in EMR. DON B stated if we (surveyors) were not there, she would have uploaded these documents into EMR. Record review revealed no hospice documentation was uploaded into the EMR under the miscellaneous tab as stated by DON B. A review of the medical record revealed R38 was admitted to the facility on [DATE] with diagnoses that included: uninhibited neuropathic bladder, weakness, difficulty walking, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. On 6/2/25 at approximately 10 AM, R38 was observed in the hallways self-propelling in a manual wheelchair. R38 was observed to have a urinary catheter collection bag hanging from the arm rest of his wheelchair (above the level of his bladder), staff were observed to walk past R38. On 6/2/25 at 10:58 AM, resident was observed lying in bed with foley catheter tubing wrapped around his right leg. R38 reported having a urinary catheter for the entire time that he had been in the facility, that he wished he did not have it and that it burns. When R38 was asked about how/where his catheter collection bag should hang, he reported that when he is in his wheelchair it normally hangs from either the handrail or the side of the frame of the wheelchair and that no one has told him where it should hang in regards to his bladder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 3:44 PM R38 observed in bed, urinary catheter leg bag in place. When asked if the staff exchange the traditional collection bag for a leg bag each day R38 reported they do it when it is possible. When asked for clarification R38 reported it is not possible for staff when they are too busy and that the big bag hold more urine. R38 confirmed he did not have a leg bag on the day prior (6/2/25). R38 reported he gets pushed to the side and that most days the staff do not exchange the traditional collection bag with a leg bag. When asked what his preference was, he reported without a doubt I would prefer a leg bag, reporting that the traditional bag/tubing gets pulled and wrapped around his leg and the bag has popped twice. When asked how often they clean his penis he reported that he didn't recall them doing it at all. On 6/4/25 at 11:30 AM R38 was observed in the dining room, awaiting his lunch. He was observed to have a traditional catheter collection bag that was attached under his wheelchair, catheter tubing was noted to be resting on the floor. It should be noted that R38 did not have a leg bag in place. On 6/4/25 at 1:07 PM, during an interview with LPN F, when asked what interventions were in place related to his urinary catheter, stated there is a securement device in place on R38's thigh and catheter care should be completed once per shift. She reported that catheter care had not been completed during her current shift. When it was reported that R38 still had a traditional urinary catheter collection bag in place and if that was typical, LPN F reported that R38 should be switched to a leg bag once he is out of bed for the day. LPN F reported that she had not seen R38 get out of bed yet. R38 had been to therapy and to the dining room for lunch that day. At 1:15 PM, LPN F was observed performing catheter care for R38. A clean towel was placed on R38's bedside table, LPN F used warm water and antibacterial soap to clean the catheter tubing at the insertion point only. LPN F did not clean any portion of the penis. R38's penis was noted to be red at the head and had a vertical tear from the urethral opening to the end of the penile head. On 6/4/25 at 1:57 PM, LPN F was asked if she knew how R38's penis got the tear, she reported that she didn't think they were able to determine the cause but that she knew that was the reason he got the order for the leg bag, because he would stand up with his catheter attached to stuff. When asked what areas she would normally clean during catheter care LPN F reported she would clean just the catheter tubing. On 6/4/25 at 2 PM, during an interview with the director of nursing (DON), when asked what she would tell me about the injury to R38's penis she reported that she was not familiar with it and began to look in his electronic chart. When asked what the expectation is for catheter care DON reported that staff perform it correctly, per policy. When asked what areas should be cleaned during urinary catheter care, DON reported meatus, foreskin, length of the penis as well as the catheter tubing. A review of R38's physicians orders revealed: 4/5/25 Change from leg bag to regular bag at HS (bedtime). 4/23/25 Change Foley to leg bag, one time a day. 5/12/25 Foley cath care every shift. A review of R38's skin assessments since his admission revealed no documentation of a penile tear. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the R38's progress notes revealed: 5/28/25 at12:14 PM, NP (nurse practitioner) Narrative (age redacted) male seen today for worsening genital burning. Pt. (patient) was up in w/c (wheelchair) propelling self .Pt seen and examined in room; indwelling catheter present and noted with lg (large) penile tear extending from glanular to shaft from long term use; catheter is secured to lt (left) thigh .current position was taunt not allowing much freedom with movement . Around top of shaft noted with redness; unsure if powder or cream applied prior; small amount of remnants remained .DERM (dermatology/skin): Skin warm and dry, lg penis tear; underside; rash to penile head and distal shaft .Assessment/Plan: Cutaneous Candidiasis (fungal infection): Mycolog Cream (antifungal cream); cleanse penis daily; pat dry. Apply cream topically BID (twice per day) and PRN (as needed) .Penile Tear: Be mindful of positioning of Grip-Lok Securement tape to lessen potential worsening of penile tear . 5/25/25 at 8:33 PM Nurses Notes: Resident complained of burning sensation related (to) his urinary catheter. Output appears large and clear . 4/17/25 at 10:12 AM Nurses Notes: (Residents name redacted) frequently moves his foley bag on back of w/c or places on w/c seat while in w/c. Education provided. 4/8/25 at 2:15 PM Nurses Notes: PT c/o (complains of) painful penis, write did assessment, PT has white discharge around head of penis, PT went to appointment with Urologist, new order for nystatin cream . 4/8/25 at 12:37 PM Nurses Notes: Received paperwork from appointment on urology. Orders received to cont. (continue) Flomax (medication to treat enlarged prostate), nystatin cream bid to tip of penis, recheck in 1 year, cont. indwelling catheter . 3/31/25 at 1:53 PM Physician Progress Note: Pt asked to be seen secondary to painful urination. Staff had a foley catheter and pulled it out . 3/31/25 at 1:47 PM Nurses Notes: Resident c/o painful urination, flank pain . 3/25/25 at 1:41 PM Nurses Notes: Resident complains of burning from catheter. Upon assessments residents tip of penis is spit (split). Updated MD. 3/25/25 at 6:40 PM Nurses Notes Resident pulled foley out, writer updated PCP (Primary care provider) and replaced foley . 3/5/25 at 9:09 AM Nurses Notes: .Resident continues to have burning in penis with yellow crusted discharge. 2/28/25 at 6:12 PM Nurses Notes: Pt c/o burning sensation, flank pain, and urine is cloudy w/ sediment present . 2/28/25 at 6:12 PM Nurses Notes: Pt c/o burning sensation, flank pain, and urine is cloudy w/ (with) sediment present . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Manor Healthcare Center	730 Kimole Lane Adrian, MI 49221

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/7/25 at 3:16 AM Nurses Notes: Resident returned from (emergency room name redacted) via ambulance transport at 0300. Resident had a foley placed, 14 fr 10cc balloon. Catheter is patent and draining yellow urine. Output at the hospital was 1000ml. Resident states he feels better, denies any pain and is resting comfortably in his bed . 2/5/25 at 10:30 PM Admission/readmission Note: Pt arrived at 1730 on previous shift via ambulance . admission assessment completed by write and documented .Skin intact, normal color for ethnicity, warm and dry. Discoloration on bilateral lower legs A review of a Urology office visit note dated 4/7/25 revealed, (R38) is an (age redacted) male here for urinary retention. Patient has a Hx (history) of enlarged prostate and was self cathing for many years/states over 10. Patient has a foley cath that was placed a few months ago after stroke/left sided weakness and is changed monthly at (facility name redacted). Patient has discomfort when standing at the tip of penis and in urethra. Urine is clear no blood in bag .Genitals circ (circumcised) (appears in last few years-wife confirms but unsure where), foley clear, testes 3/3 bil (bilateral) .Discussed plan of care with pt and wife. Went over history, exam, plan of care. Hopefully would be able to go back to straight cathing in the future but for now it does not feel like his left arm is strong enough and patient is confused even though as to where he lives right now so I do not think having him do it twice a day is a good option. In the future if he goes home and has visiting nurses come he may be able to do the cathing again but for now I think the best option would be to do the indwelling catheter with changes monthly. We talked about nystatin cream for his penis as it is slightly irritated but many need to change this if it is not helpful in the future . It should be noted that there was no mention of a penile tear in the details of the urology report from 4/7/25. A review of the facilities policy, titled Catheter Care. Documented in part .Male: Gently grasp penis, draw foreskin back if applicable, using circular motion, cleanse the meatus moving down, cleanse the shaft of the penis, with a new moistened cloth, starting at the urinary meatus outward, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter, dry area with towel . A review of the facilities policy, titled Indwelling Catheter Use, documented in part Additional care practices include: .Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears of dislodgement of the catheter, and Securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure for four out of four residents (Resident #14, 18, 35 and 37) cigarettes, lighters, and vaps were stored in a secured manner. Findings Included: Resident #14 (R14): Review of a SMOKING-SAFETY SCREEN dated 2/20/2024, revealed R14 was screened to be safe to smoke independently and without supervision. The screen also revealed R14 did not require the facility to store his light or cigarettes. Review of a care plan that was in place with a Focus of (R14) is a smoker dated 2/20/24 and revised on 4/23/2024, revealed under the interventions, (R14's) smoking supplies are stored with (R14). The care plan did not include how R14 was to safely store the cigarettes and lighter to prevent other residents from obtaining the cigarettes and/or lighter while the products were stored in R14's room. Resident #35 (R35): Review of a SMOKING-SAFETY SCREEN dated 12/9/2024, revealed R35 was screen to be an independent smoker, could light cigarette, and dispose of cigarette. The screen revealed R35 also used a [NAME], and did not need the facility to store lighter and cigarettes for him. Review of a care plan in place with a Focus of (R35) is a smoker revealed an intervention of, (R35) smoking supplies are stored with (R35). The care plan did not include how R35 was to safely store the cigarettes and lighter to prevent other residents from obtaining the cigarettes and/or lighter while the products were stored in R35's room. In an observation on 6/03/2025 at 8:38 AM, it was observed, that a pack of cigarettes and two lighters were inside of a baseball cap on R35's over the bed table. R35 stated that he did not have to keep the cigarettes and lighters locked up or secured, and was able to go smoke at his leisure. During an interview on 6/04/2025 at 12:13 PM, Director of Nursing (DON) B was asked if residents were to secure/lock up smoking items if the items were stored in the resident's room. DON B stated the residents did not like having to wait for a nurse to unlock the medication cart, and get their cigarettes and lighter for them. DON B was asked if she knew how many lighters, vaps, and packs of cigarettes were being stored in resident rooms in order to assure items were not coming up missing, in which DON B stated no. Review of the facility policy and procedure titled Smoking Policy-Residents dated 5/4/2022, revealed no language regarding securing/locking up cigarettes, lighters, or vaps when a resident was able to keep those items in their rooms. The policy did not speak to residents having the ability to keep the items in their rooms. Resident #18 (R18) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record reflected R18 was an initial admission to the facility on [DATE] and readmitted after a hospital stay on 03/24/2023. Diagnoses of heart failure, Dysphagia (difficulty swallowing), Aphasia (difficulty communicating due to stroke), muscle weakness, abnormal gait and a history of a stroke. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2025 revealed R18 had a Brief Interview of Mental Status (BIMS) of 13 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R18 requires assistance with personal care and uses a wheelchair as an assistive device. During an interview on 06/03/25 at 12:03 PM, R18 could answer questions by nodding her head or pointing to the item. Writer asked R18 if she was a smoker, and she nodded her head yes. Writer asked where she kept her cigarettes and lighter, she pointed to her top drawer, writer asked permission to open the drawer, and she nodded her head yes. No cigarettes or lighter visible in her drawer. Writer asked if she had to keep her cigs and lighter locked up, she nodded her head yes and pointed out in the hallway, writer asked her if she kept them in the medication cart and she nodded her head yes. During an interview on 06/03/25 at 12:07 PM, DON B stated all the smoking residents keep their cigarettes, lighters, and vape devices in their rooms. DON B stated they did a smoking assessment and determined if they could smoke independently or not and if so, they could keep their supplies in their room. DON B also stated the residents could store smoking supplies in their rooms as it is their property. Record review revealed R18 had a previous smoking assessment dated [DATE], it was a smoking agreement that was signed by R18. R18 was no longer able to smoke independently as documented on her smoking letter dated 06/25/24 and signed by LNA A. This smoking document stated R18 was non-compliant with the smoking agreement, so her smoking devices needed to be always locked up with the nursing staff. This same document had the date crossed out and dated 06/25 with staff initials. During an interview on 06/03/25 at 3:54 PM, Licensed Practical Nurse (LPN) F stated R18 had her cigarettes and lighter in her room. LPN F also stated she could keep them with her in her room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/04/25 at 12:13 PM, DON B stated only the smokers got the smoking assessment. Shows how often they smoke, what they smoke, care planned yes/no, and if nursing staff had to keep items locked up. DON B also stated they look at how they light it, do they need assistance, can they smoke on their own, can they put out the cigarette themselves. DON B also stated the smoking assessment form shows dependent or independent outside in the courtyard. DON B stated residents with supervised smoking is someone who needs assistance with lighting the cigarette, holding of the cigarette, and they would have certain smoking times. DON B stated they currently do not have anyone that needs help/supervising while smoking. DON B stated residents smoking unsupervised, means they can smoke when they want to, could go in and out of the courtyard as they want to, no set times. DON B added there is no need for any staff to be out there with them because of their smoking agreement. They can keep their own smoking parafunctional in their room in their possession. DON B stated they look at residents Brief Interview for Mental Health (BIMS) score so if they are over a 11-12 and above can keep items in their smoking paraphernalia in their room. Writer asked if she had any concern with fire risk at the bedside, DON B stated no. Writer asked if the smoking paraphernalia was secured in their room? DON B stated no, it is in their room or in their pockets. Writer asked DON B how she assured other residents did not get a hold of these. DON B stated they had not had that problem before. Writer asked DON B if she was aware the smoking residents were leaving their paraphernalia sitting out on the over the bed table. DON B stated she was not aware of any residents leaving their smoking items out in the open. Writer asked DON B if R18 was a supervised smoker, due to the smoking letter that stated she was non-compliant and no longer allowed to smoke independently. DON B stated this resident was an independent and could keep her smoking items in her room. Writer asked DON B why R18 had a smoking agreement that documented that she was non-complaint with the smoking agreement and was now supervised as of 06/24/2024 and that date is crossed out with 06/25 written through it and it was initialed. DON B stated R18 was independent, and she was unaware of the letter stating she was no longer independent. Resident #37 (R37) Review of the medical record reflected R37 was an initial admission to the facility on [DATE] and admitted to hospice on 01/16/2025. Diagnoses of Chronic Obstructive pulmonary Disease, Non-ST Elevation (NSTEMI) Myocardial Infarction, Acute Kidney Failure and lack of Coordination. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/22/2025 revealed R37 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R37 requires assistance with personal care and uses a walker or wheelchair as an assistive device. During an observation on 06/02/25 at 2:06 PM, R37 had a pack of cigarettes and 2 lighters (1 blue and 1 red) sitting on his over the bed table, a blue plastic bowl sitting on his heat/cooling register with 1 single cigarette and a green lighter, and an inhaler. R37's oxygen was turned off and his nasal cannula was draped over the O2 concentrator. Record review revealed R37 did not have an updated smoking safety screen since his admission. One was completed today while this survey was in progress at 2:20pm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/03/25 at 11:51 AM, R37 stated he kept his smoking paraphernalia in his dresser drawer. R37 stated there was no limit on the number of cigarettes or lighters they can have. R37 stated they were expected to manage their own cigarettes and lighters. Writer asked R37 if he had had any incidents of other residents coming in his room trying to take his lighters or cigarettes, he stated not really. During an interview on 06/03/25 at 12:07 PM, DON B stated all the smoking residents keep their cigarettes, lighters, and vape devices in their rooms. DON B stated they did a smoking assessment and determined if they could smoke independently or not and if so, they could keep their supplies in their room. DON B also stated the residents could store smoking supplies in their rooms as it is their property. During an interview on 06/03/25 at 3:54 PM, Licensed Practical Nurse (LPN) F stated R37 had his cigarettes and lighter in his room. LPN F also stated he could keep them with her in her room. During an interview on 06/04/25 at 12:13 PM, DON B stated only the smokers got the smoking assessment. Shows how often they smoke, what they smoke, care planned yes/no, and if nursing staff had to keep items locked up. DON B also stated they look at how they light it, do they need assistance, can they smoke on their own, can they put out the cigarette themselves. DON B also stated the smoking assessment form shows dependent or independent outside in the courtyard. DON B stated residents with supervised smoking is someone who needs assistance with lighting the cigarette, holding of the cigarette, and they would have certain smoking times. DON B stated they currently do not have anyone that needs help/supervising while smoking. DON B stated residents smoking unsupervised, means they can smoke when they want to, could go in and out of the courtyard as they want to, no set times. DON B added there is no need for any staff to be out there with them because of their smoking agreement. They can keep their own smoking parafunctional in their room in their possession. DON B stated they look at residents Brief Interview for Mental Health (BIMS) score so if they are over a 11-12 and above can keep items in their smoking paraphernalia in their room. Writer asked if she had any concern with fire risk at the bedside, DON B stated no. Writer asked if the smoking paraphernalia was secured in their room? DON B stated no, it is in their room or in their pockets. Writer asked DON B how she assured other residents did not get a hold of these. DON B stated they had not had that problem before. Writer asked DON B if she was aware the smoking residents were leaving their paraphernalia sitting out on the over the bed table. DON B stated she was not aware of any residents leaving their smoking items out in the open.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to limit the duration of a PRN (as needed) psychotropic medication to 14 days and/or ensure the physician documented rationale to extend the duration of use for one (Resident #2) out of five reviewed for unnecessary medications. Findings include: Resident #2. (R2) Review of the medical record reflected R2 was an initial admission to the facility on [DATE] and admitted to hospice on 05/16/2025. Diagnoses of Chronic Obstructive Pulmonary Disease, Diabetes, Acute Kidney Failure, Chronic Kidney Disease, Stroke and unsteadiness on feet. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2025 revealed R2 had a Brief Interview of Mental Status (BIMS) of 11 (moderately impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R2 is dependent with all care and uses an electric wheelchair as an assistive device. Record revealed R2 had Ativan oral tablet 0.5mg, give 1 tablet by mouth every 4 hours as needed for anxiety, start date of 05/16/2025 with no end date. Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, shortness of breath, start date of 05/16/2025 with no end date. Hydrocodone/acetaminophen oral tablet 5/325mg, take one tablet by mouth every 6 hours as needed for pain, maximum daily amount 4 tablets a day, start date of 04/27/2025 with no end date. Record review of the Medication Administration Record (MAR) for the month of May 2025 showed R2 did not receive any Ativan 0.5mg tablets. R2 requested Hydrocodone 5/325mg tablet three times for a pain rated 5-7 on a scale of 0-10. R2 did not request any Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, or shortness of breath. Record review of the MAR for the month of June 2025 showed R2 did not receive any Ativan 0.5mg tablets. R2 requested Hydrocodone 5/325mg tablet three times for a pain rated 5-7 on a scale of 0-10. R2 did not request any Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, or shortness of breath. During an interview on 06/04/2025 at 8:21AM, SWD C stated his role is to get the consents for the use of these medications and nursing is the one who addresses them. SWD C added they do not like prn's, they do a 14-day trial and see how often they use it, they try to use non-pharmacal first. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/04/25 at 8:37 AM, DON B stated there would be a 14 day stop date and provider had to write a note. Hydrocodone/acetaminophen oral tablet 5/325mg, take one tablet by mouth every 6 hours as needed for pain, maximum daily amount 4 tablets a day, start date of 04/27/2025 with no end date. DON B added providers just leave that as needed, if pharmacy had not caught it, they usually do. Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, shortness of breath, start date of 05/16/2025 was ordered from hospice and Hydrocodone/acetaminophen oral tablet 5/325mg, take one tablet by mouth every 6 hours as needed for pain, maximum daily amount 4 tablets a day, start date of 04/27/2025 was ordered prior. DON B stated they would not stop the as needed medications or give an end date. These as needed orders were written by DON B. Per the State Operation Manual (SOM) . PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication . Record review of all discipline progress notes revealed no pain or anxiety re- assessments following the addition of Hydrocodone/acetaminophen oral tablet 5/325mg, take one tablet by mouth every 6 hours as needed for pain, maximum daily amount 4 tablets a day, start date of 04/27/2025, Ativan oral tablet 0.5mg, give 1 tablet by mouth every 4 hours as needed for anxiety, start date of 05/16/2025 with no end date. Morphine Sulfate (Concentrate) Oral Solution100 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain 7-10, shortness of breath, start date of 05/16/2025, within the 14 days following the starting of these medications as recommended by the SOM. There was no documentation that these medications were still needed or not.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 71 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage. Findings include: On 06/02/25 at 09:40 A.M., An initial tour of the food service was conducted with Dietary Director (DD) G. The following items were noted: The Scottsman ice machine entrance door (misaligned) and front panel cover plate were observed broken. (DD) G stated: I will contact maintenance for repairs. The 2022 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. The Scottsman ice machine ice scoop clear plastic caddy was observed soiled with accumulated and encrusted mineral (calcium and lime) deposits. (DD) G stated: I will have staff clean the caddy now. The Vulcan convection oven interior and exterior surfaces were observed soiled with accumulated and encrusted food residue. (DD) G indicated he would have staff thoroughly clean and sanitize the oven interior and exterior surfaces as soon as possible. The can opener assembly was observed soiled with accumulated and encrusted food residue. The can opener mounting bracket assembly was also observed soiled with accumulated and encrusted food residue. (DD) G indicated he would have staff thoroughly clean and sanitize the can opener and mounting bracket assemblies as soon as possible. The Vulcan griddle backsplash and corner edges were observed with accumulated and encrusted food residue. (DD) G indicated he would have staff thoroughly clean and sanitize the griddle surfaces as soon as possible. The CPG (Cooking Performance Group) oven interior and exterior front burner panel was observed with accumulated and encrusted food residue. (DD) G indicated he would have staff thoroughly clean and sanitize the exterior oven surfaces as soon as possible. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The mechanical dish machine wash temperature gauge was observed to read 115 degrees Fahrenheit during the operational cycle. (DD) G stated: I will contact maintenance for repairs. The 2022 FDA Model Food Code section 4-501.110 states: (B) The temperature of the wash solution in spray-type warewashers that use chemicals to SANITIZE may not be less than 49oC (120oF). The wash solution temperature in mechanical warewashing equipment is critical to proper operation. The chemicals used may not adequately perform their function if the temperature is too low. Therefore, the manufacturer's instructions must be followed. The temperatures vary according to the specific equipment being used. Record review of the Policy/Procedure entitled: Dietary Department Guidelines dated 01/15/2025 revealed under The Facility: (1) The dietary department will be maintained in a clean and sanitary manner to prevent foodborne illness. Record review of the Policy/Procedure entitled: Dietary Department Guidelines dated 01/15/2025 further revealed under Equipment: (1) All food preparation equipment, dishes, and utensils must be maintained in a clean, sanitary, and safe manner, used and repaired according to manufacturer's recommendations. Record review of the Policy/Procedure entitled: (Facility Name) dated (no date) revealed under Policy Statement: (Facility Name) will maintain food service equipment to ensure food safety, operational efficiency, and compliance with health regulations.