Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Grand Rapids Home for Veterans

Location: 2950 Monroe N.E. Grand Rapids, MI 49505

Onsite / Virtual: Onsite

Dates of Survey: 12/9/25 - 12/12/25

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 128

Census on First Day of Survey: 118

Surveyed By: Jacqueline Hunter, Generalist; Deanna Kramer, RN; Nomie Wallace, MS; Melissa Mrotek, Generalist; Seth Maxwell (LSC); Cicely Robinson, VACO.

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from December 9, 2025, through December 12, 2025 at the Grand Rapids Home for Veterans. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Rating** – Not Met **Scope and Severity** - D **Residents Affected** – Few	Based on observation, resident interview, staff interview, clinical record review and policy review, the facility failed to ensure medications were administered in accordance with professional standards of practice for one (1) of six (6) residents sampled for medication review. The findings include: Review of the policy titled, “Clinical Services & Quality of Care Medication Administration,” last reviewed on 2/20/25 found: “Policy - Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the provider and in accordance with professional standards of practice, in a manner to prevent contamination or infection. GUIDELINES Policy Interpretation and Implementation:…

	8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the provider's prescribed parameters…15. Administer medication as ordered in accordance with manufacturer specifications…21. Sign MAR after administration. For those medications requiring vital signs, record the vital signs onto the MAR…26. Medication timing (excluding insulin) is home-specific, and the time schedule will be provided by the home." Resident #6 was admitted to the facility on 7/23/24 with diagnoses that included Chronic Kidney Disease, Hemiplegia and Hemiparesis following other Cerebrovascular Disease Affecting Left Non-Dominant Side, Dysarthria Following Other Cerebrovascular Chronic Kidney Disease, Need for Assistance with Personal Care, Unspecified Dementia, Essential Hypertension, Hypotension, and Tachycardia Disease. Review of the quarterly Minimum Data Set (MDS) dated 10/13/25 identified the Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated the resident was cognitively intact. Review of the Medication Administration Record (MAR) revealed the following medications were to be administered on 12/9/25 at 11:00 a.m.: -Start date 10/23/25 Allopurinol Oral Tablet 100 MG (milligrams) Give one (1) tablet by mouth one (1) time a day every Tue., Thu., Sat. for Gout. -Start date 10/22/25 Amiodarone Hydrochloride (HCl) Oral Tablet 200 MG Give one (1) tablet by mouth one (1) time a day for Paroxysmal Atrial Fibrillation (A-Fib). -Start date 10/22/25 Clopidogrel Bisulfate Tablet 75 MG Give one (1) tablet by mouth one (1) time a day for Heart Attack. -Start date 10/26/25 Docusate Sodium Capsule 100 MG Give one (1) capsule by mouth one (1) time a day every other day for Constipation Hold if loose stools. -Start date 10/22/25 Duloxetine HCl Capsule Delayed Release Particles 30 MG Give one (1) capsule by mouth one (1) time a day for Post-Traumatic Stress Disorder, Unspecified. -Start date 10/21/25 Eliquis Oral Tablet 2.5 MG (Apixaban) Give one (1) tablet by mouth two (2) times a day for A-Fib - Anticoagulation -Start date 10/23/25 Famotidine Oral Tablet 10 MG Give one (1) tablet by mouth in the morning every Tue, Thu, Sat, Sun for Gastroesophageal Reflux Disease (GERD). -Start date 10/22/25 Fexofenadine HCl Oral Tablet 60 MG Give one (1) tablet by mouth one (1) time a day for allergic Rhinitis, monitor for any Anticholinergic side effects.

	-Start date 11/26/25 Hydroxyzine HCl Oral Tablet 10 MG Give one (1) tablet by mouth every 24 hours as needed for Pruritus for 14 days -Start date 10/22/25 Isosorbide Mononitrate ER Oral Tablet Extended Release 24 Hour 30 MG Give one (1) tablet by mouth in the afternoon for cardiac output, do not crush HOLD if Systolic Blood Pressure (SBP) <110. -Start date 10/29/25 Pregabalin Capsule 25 MG Give one (1) capsule by mouth two (2) times a day for Type 2 Diabetes Mellitus With Diabetic Neuropathy. -Start date Sevelamer HCl Tablet 800 MG Give three (3) tablets by mouth three (3) times a day every Tue, Thu, Sat, Sun for Hypocalcemia before meals. -Start date 10/23/25 Torsemide Oral Tablet 5 MG Give one (1) tablet by mouth one (1) time a day every Tue., Thu., Sat., Sun. for CKD (Chronic Kidney Disease) stage 5 / HTN (Hypertension). During the initial tour on 12/9/25 at 12:36 p.m., Resident #6 was sitting in his/her motorized wheelchair in the dining room finishing lunch. There was also a medication cup with approximately 14 medications in it on the table and a small cup of water. He/she stated that the nurse administers the medication at times and other times he/she takes the medication alone. At 12:51 p.m., the resident stated he/she would be right back and left the table. No other residents were in the dining room area. Resident #6 left to retrieve the nurse who left the medication on the table. During an interview on 12/9/25 at 12:52 p.m., Licensed Professional Nurse (LPN) E stated he/she delivered the medication to Resident #6 but did not administer the medication because he/she was eating. LPN E was identifying the medications in the medication cup and stated they were scheduled for administration at 11:00 a.m. LPN E stated Resident #6 was able to take medication independently/self-administer and he/she had an assessment to self-administer medication. He/she stated they prepared the medication and gave it to the resident. He/she further stated the process was staff was “supposed to stand there till [he/she] takes them to make sure that [he/she] takes them”; majority of the time I watch them. [He/she] came to eat and [I] brought them over.” At 12:54 p.m., He/she handed [him/her] the medication cup and water and the resident took pills. LPN E further stated, “I left the pills on the table and went back to my cart, back to fill water, juice for another member for [his/her] medication. [He/she] was still eating – [he/she] was the only one [1] in here; the others had left.” LPN E stated the definition for self-administration was the nurses pulled pills and handed them to the resident and they took them. He/she stated, “I set them down because I knew

	[he/she] was going to take them after [he/she] ate. I should have stayed here with [him/her]." During a review on 12/10/25 at 2:15 p.m., the Director of Nursing (DON) reviewed the December MAR on his/her computer to verify that LPN E had initialed administration and the time of administration. He/she stated the nurse signed the MAR as administered at 11:14 a.m. The DON explained the process to administer medication was: The nurse was supposed to make sure the resident was available and ready to receive the medication, pull the medication list (MAR) up on the computer, compare each medication in the drawer to what was on the screen to verify it was the correct medication, the correct dose, the correct time, and then administer as ordered. The DON stated the nurses would not leave medication with a resident if they were not ready. He/she stated the nurse could have put the medication in the medication cart, if the resident was not ready to take them, for a brief period, until they were ready. He/she stated the nurses were able to destroy them if they needed to. The DON stated LPN E should have called the provider to make sure he/she could administer the medication at 12:56 p.m. The DON stated it was important for nurses to administer the medication appropriately for the residents' safety, to make sure the medication times did not overlap in times or become more or less potent with meals or without meals.
§ 51.120 (i) – Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **Rating** – Not Met **Scope and Severity** - G **Residents Affected** – Few	Based on interview, clinical record review, and review of facility reports and policies, the facility failed to provide needed monitoring and interventions for a resident who had histories of elopement (9/2023) and a suicide attempt (1/2024) for one (1) of one (1) resident reviewed for sentinel events (Resident #18). On 12/4/25, Resident #18 left the facility and did not return. Facility staff did not initiate a search for the resident in a timely manner, and on 12/5/25, police located Resident #18's body under a bridge in a river. The resident was expired. The high temperature for 12/4/25 was 29 degrees Fahrenheit (F) and the low for that day was seven (7) degrees F. https://www.weather.gov/grr/GrandRapids2025ClimateGraphs The findings include: Review of the facility's "Elopement and Wandering Members" policy with an effective date of 3/10/21 and last reviewed on 12/4/24 noted: "Policy – The purpose of this policy is to ensure that members who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk." According to the policy, elopement "occurs when a member leaves the premises or a

	safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so…GUIDELINES – Policy Interpretation and Implementation…3. The home shall establish and utilize a systematic approach to monitoring and managing members at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing a. Members at Risk for Elopement of Unsafe Wandering throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk to develop a person-centered care plan. c. Interventions to increase staff awareness of the member's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the member's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Licensed nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of intervention will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. 5. Procedures for Locating Missing Resident a. Any staff member becoming aware of a missing member will alert personnel using the home's approved protocol (e.g., internal alert code). b. Designated home staff will search for the member in the building and on the grounds. c. If the member is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between the home and the police department…6. Procedure Post-elopement:…g. Documentation in the medical record will include findings from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable." Review of the facility's "Accidents/Incidents, Investigation and Reporting" policy with an effective date of 4/29/21 and last reviewed 7/10/25 revealed the policy defined an "Accident" as "any unexpected or unintentional incident, which results or may result in injury or illness to a member;" and defined an "Incident" as an "occurrence or situation that is not consistent with the routine care of a member…" According to the policy, elopement and suicide or attempted suicide were considered incidents that required documentation, assessment, reporting. Review of the facility's "Clinical Services & Quality of Care Safety & Accident Prevention Signing Members Out" policy last reviewed on 3/11/25 noted: "GUIDELINES – Policy Interpretation and Implementation: 1. Each member leaving the

	premises (excluding transfers/discharges) must be signed out. 2. A sign-out register is located at each nurses' station. Registers must indicate the member's expected time of return…6. Staff observing a member leaving the premises and having doubts about the member being properly signed out, should notify their supervisor at once…9. Members must be signed in upon return to the home." Review of Resident #18's clinical record revealed the resident was admitted into the facility on 10/11/22 and had diagnoses that included: Generalized Epilepsy and Epileptic Syndromes, Atherosclerotic Cardiovascular Disease, Vascular Dementia, Post-Traumatic Stress Disorder (PTSD), Encephalopathy, Delusional Disorder, and Major Depressive Disorder. Resident #18's Minimum Data Set (MDS) assessments reviewed between 2/6/25 through 10/27/25 revealed the following: Quarterly MDS dated 2/6/25 revealed the resident scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognition. The MDS indicated the resident exhibited no signs of Depression and had no adverse behaviors during the assessment period. The resident was ambulatory and utilized no mobility devices. Quarterly MDS dated 5/7/25 noted the resident's cognition was intact after scoring 14 out of 15 on the BIMS assessment. Resident #18 had minimal signs of Depression and exhibited the behavior of rejecting care for one (1) to three (3) days during the assessment period. The resident remained independent with ambulation. Annual MDS dated 8/6/25 revealed Resident #18 was cognitively intact; had minimal signs of Depression; and exhibited no adverse behaviors during the assessment period. According to the assessment, it was "Somewhat important" for Resident #18 to "go outside to get fresh air when the weather is good." Quarterly MDS dated 10/27/25 revealed the resident was cognitively intact; had minimal signs of Depression; and had no adverse behaviors during the assessment period. The resident was ambulatory and utilized no mobility devices. Review of the "VHA Issue Brief" report dated 12/5/25 noted Resident #18 "signed himself off [his/her] household at 12:45pm [sic] on 12/4/25. He is independent with all care and would go outside and walk around the property, typically out front by the

	fountain and big flag area. Veteran was seen on camera leaving the front entrance of the home at 12:50pm [sic] with a warm hat, boots, and coat on. [He/She] was not wearing [his/her] glasses, and [he/she] did not take [his/her] phone with [him/her]. As part of [his/her] regular routine, Veteran regularly checks [him/her]self out of [his/her] household at the Veterans Home to go on long walks inside and outdoors, and to otherwise walk around. [He/She] was not assessed as at risk of eloping. That routine continued yesterday, 12/4/25, when [Veteran] checked out and left the building. The major difference is he did not return. As evening arrived, staff became concerned, and law enforcement was notified, and [the facility] actively searched for Veteran…[He/She] did have a suicide attempt on January 1, 2024, while [he/she] was placed in our memory care area due to a medical decline at the time causing extreme confusion. [He/She] had improved over the last couple of years back to an independent status and [his/her] [child and legal guardian] wanted [him/her] to be able to have freedom to leave the home and walk around outside again." Review of the facility's "Investigation Summary" (not dated) provided to the survey team on 12/12/25 noted Resident #18 "struggled with many physical and social determinants" which included the resident's new diagnosis of epilepsy. The summary revealed that "in September of 2023 [Resident #18] had a very sudden cognitive and medical decline. [He/She] was assessed by social services at this this time to have a BIMS [Brief Interview for Mental Status] score of 7 [seven]. [Resident #18's] care plan was updated to reflect [his/her] need for increased supervision…[his/her] guardian, additionally agreed it was best for [Resident #18] to be moved to a secure memory care household after [he/she] eloped through a courtyard gate on 9/21/23…On January 1, 2024, [Resident #18] was transferred for an inpatient psychiatric hospitalization for attempting suicide by tying a shoelace around [his/her] neck." Continued review noted the resident returned to the facility's memory care household after the inpatient psychiatric stay and remained on that unit until 2/20/24 when [he/she] was "moved to a 'regular' household…On March 8, 2024, [Resident #18] was assessed to have a BIMS score of 15 and be cognitively intact again…Once improved, [Resident #18] had begun requesting to be able to go one unsupervised walks again off the household. [Resident #18's guardian] agreed to allow [him/her] this freedom but was to walk inside the home with the placement on a wander guard to ensure [he/she] did not go outside unsupervised. [Resident #18] was permitted to walk outside with staff or volunteers, but [he/she] would become agitated that [he/she] had to have someone with [him/her] for [his/her] walks.

	After several months of going along with [his/her] [guardian's] wishes, [Resident #18] voiced the desire to be able to walk outside again unsupervised. The IDT [interdisciplinary team] along with [Resident #18] and [Resident #18's guardian] determined that the benefits of allowing [him/her] the freedom to walk outside alone outweighed the risks of a negative outcome such as a fall or getting lost while on [his/her] walks. [Resident #18's] guardian had also determined that the air tag on {Resident #18's] wallet (used to locate it when [he/she] misplaced it) and the staff hourly checks could be discontinued due to [his/her] irritation of feeling like [he/she] is being 'followed' and 'checked on'…The home informed [Resident #18] and [his/her guardian] of the risk of allowing [Resident #18] to continue to sign [him/her]self out and walk as [he/she] desired. [Resident #18 and his/her guardian] felt these risks outweighed [Resident #18's] negative feelings, were the least restrictive to [his/her] freedom of movement, and supported [his/her] rights to sign in and out of the home as [he/she] desired so long that [his/her] cognitive and physical abilities did not decline. [Resident #18's] care plan goal were [sic] to continue to remain as independent as possible while the home continued to monitor to ensure there were not any declines. Continued review of the "Investigation Summary" noted that it was "daylight, 32 degrees, dry and sunny" when Resident #18 left from the front entrance of the home on 12/4/25 at 12:50 p.m. The source of this forecast information detailed in the summary was not listed. Review of the summary revealed that when Resident #18 could not be found, police were notified and a search was started on the evening of 12/4/25. "At around 4:00pm [sic], on 12/5/25, [the police] notified [the resident's guardian/adult child] and the home's administrator that the body of [Resident #18] was discovered in a remote area on the west bank of the Grand River. [Resident #18] was found standing in waist high water, hat was still on [his/her] head, gloves and coat on. The water was frozen all around [him/her]. The police state that it had appeared that [Resident #18] had walked into the water on [his/her] own accord they were not concerned with foul play." The survey team requested to review the police report; however, it was not available for review during the survey dates 12/9/25 through 12/12/25. Further review of the summary revealed that the facility's Activity Therapy Assistant (ATA) told Resident #18 that "it was cold outside" when Resident #18 told the staff that he/she was "going to go for a walk." Another facility aide reported that on the morning of 12/4/25, "[he/she] noticed that [Resident #18] gave another member a handshake which [he/she] thought was a little strange." According to the "medical record review," [Resident #18's] "elopement risk assessment score did have [him/her] marked as a 1 [one] on 9/8/25 only because of the one

	(1) past elopement attempt when [he/she] had a medical decline in 2023." The summary of the investigation concluded that "The home determined that this event does not meet the definition of 'elopement' as it states an 'elopement occurs when a member leaves the premises or a safe area without authorization and/or any necessary supervision to do so…[Resident #18] did have a routine pattern; [he/she would eat meals in the dining room, take [his/her] medications, and then be on and off the household…On the day of 12/4/25, [he/she] did not take [his/her] 2pm [sic] medications which may have been considered unusual for [Resident #18], however, there was an agency nurse [Licensed Practical Nurse {LPN) I] working until 3pm [sic] and would not have been aware of this pattern…The home has determined the root cause to be that [Resident #18] desired to end [his/her] own life. [Resident #18] did not express this to anyone." Review of Resident #18's "Certificate of Death" noted the date of the resident's death was "on or about" 12/4/25. The certificate listed "Asphyxia by drowning" as the "underlying or contributing cause of death; and listed Atherosclerotic Cardiovascular Disease as a significant condition that contributed to death but not resulting in the underlying cause. The certificate listed the "Manner of Death" as an "Accident." An autopsy was performed and the certificate noted that Resident #18 "entered water and drowned." "Staff or Volunteer Interview Summary" statements were reviewed in reference to Resident #18 leaving the facility grounds on 12/4/25, and documented the following: 12/5/25 - Licensed Professional Nurse (LPN) I who worked on Resident #18's unit from 12:00 p.m. until 3:00 p.m. on 12/4/25 revealed Resident #18 "was due for oxy (Oxycodone – an opioid pain medication) at 2 p.m. so I went to check [his/her] room and [he/she] still wasn't back at 3 p.m. so I put in the note the [sic] I was not able to give [him/her] [his/her] meds." 12/5/25 - LPN K said he/she took over for LPN I "around 3 pm." [sic] LPN I was providing resident a treatment at the time, so RN J gave report. During report, it was said that Resident #18 "was off the household – we thought [he/she] was at an activity." According to LPN K, RN J reported that Resident #18 "signed out at 1 pm [sic] – [he/she] hadn't got [his/her] Vitamin D or Oxy [sic]. Around 4:45 p.m., LPN K went to Resident #18's room and noticed his/her bed was not made "which was weird so thought maybe [he/she] went to do laundry." When Resident #18 was not in the dining room before 5:00 p.m. for the dinner meal, LPN K prompted Certified Nursing Aide (CNA) G to check the laundry

	rooms to locate Resident #18. LPN K reported that the resident could not be located at that time. 12/5/25 at 12:35 p.m. - CNA G reported that he/she saw Resident #18 during the breakfast meal on 12/4/25 and the resident gave a handshake to another resident which CNA G thought was “a little strange.” The aide saw the resident signing out at 12:45 p.m. and around 3:20 p.m., CNA G looked for Resident #18 “but didn’t find [him/her].” Around 5:00 p.m., LPN K asked CNA G if he/she had seen the resident, and the aide said that Resident #18 “had been outside.” The staff became concerned and started searching for the resident. 12/5/25 at 1:57 p.m. - Statement from Activity Therapy Assistant (ATA) L revealed on 12/4/25, Resident #18 “walked by and tapped me on shoulder.” [sic] ATA L reported that Resident #18 said to him/her “I think I’m going to go for a walk,” and ATA L told the resident that “It’s cold outside.” Resident #18 said to ATA L “That’s ok I won’t be out too long.” ATA L said the resident went for little walks and got fresh air. 12/8/25 at 1:21 p.m. - Registered Nurse (RN) J administered medications on the unit starting at noon and left the unit at 3:00 pm at shift change. RN J said that LPN I reported to LPN K that Resident #18 did not get his/her 2:00 p.m. dose of pain medications. Resident #18’s “Elopement Evaluation” assessments were reviewed between 12/3/24 and 9/8/25 the following instruction and questions were noted on the form: “1. Complete for residents who ambulate independently with or without the use of an assistive device or wheelchair; 2. Does the resident have a history of elopement or an attempted elopement while at home; 3. Does the resident have a history of elopement or attempted elopement leaving the facility without informing staff; 4. Has the Resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door; 5. Does the Resident wander; 6. Is the wandering behavior a pattern, goal-directed (i.e. specific destination in mind, going home, etc.); 7. Does the resident wander aimlessly or non-goal-directed (i.e., confused, moves with purpose, may enter others’ rooms and explore others’ belongings); 8. Is the Resident’s wandering behavior likely to affect the safety or well-being of self/others; 9. Is the Resident’s wandering behavior likely to affect the privacy of others; 10. Has the Resident been recently admitted or re-admitted (within past 30 days) and is not accepting the situation; 11. Score value of 1 or higher indicates Risk of Elopement.”

	The "Elopement Evaluation" scores were as follows: 12/3/24 – Score of two (2) which indicated Resident #18 had a risk of elopement. 3/5/25 – Score of zero (0) which indicated there was no risk of elopement. 6/4/25 - Score of zero (0) which indicated there was no risk of elopement. 9/8/25 – Score of one (1) which indicated Resident #18 had a risk of elopement. Due to Resident #18's elopement history, and his/her expression of his/her desire to move back home, the resident should have scored a two (2) on the "Elopement Evaluations" dated 3/5/25, 6/4/25, and 9/8/25. Resident #18's "Comprehensive Care Plan" initiated on 10/20/22 was reviewed and revealed the resident's care plan areas included, but were not limited to, the following: Problem: Resident #18 "has a PASARR [Preadmission Screening and Resident Review] Level II r/t [related to] DX [diagnoses] of Major Depressive Disorder, Post Traumatic Stress Disorder, and Unspecified Neurocognitive Disorder. [Resident #18] experienced an inpatient psychiatric hospitalization in 1/2024 r/t suicide attempt via tying a shoelace around [his/her] neck. [Resident #18] will minimize the severity of the attempt when discussing it with staff/others (4/23/25). Problem: Resident #18 "has impaired cognitive function r/t DX of Dementia, PTSD, and Delusional Disorder. Noted with impairment in judgement, abstraction, perception, and reasoning. Occasionally has difficulty word-finding…[Resident #18] will engage in sarcastic banter with staff members that [he/she] gets along with and to potentially mask cognitive deficits (initiated 10/28/22 and revised on 2/7/25)." One of the interventions noted "[Resident #18's] cellphone received a scandent (tracking tag) on 9/10/24" to assist in monitoring his/her location. Problem: Resident #18 "is at [the facility] for long-term care d/t [due to] increased confusion and needing increased assistance with ADL [activities of daily living] tasks…[Resident #18] has verbalized difficulty accepting LTC placement d/t frustration with limited movement, independence, and heightened oversight. He will periodically bring up wanting to move back to the UP [Upper Peninsula of Michigan] to live independently, but that is not a safe option at this time. [Resident #18] does acknowledge

	[his/her] inability to live alone d/t [his/her] medical conditions (initiated 9/25/23 and revised on 2/7/25)." Problem: Resident #18 "uses psychotropic medications r/t Dementia, Delusional Disorder, and PTSD…Symptomology: Paranoia and other delusional thoughts, agitation, irritability, yelling, resisting care, labile affect, anger, threatening behavior, depressed mood, hitting self, suicide ideation w/ [with] an attempt, restlessness, feeling isolated, helpless/worthless, and feeling imprisoned (initiated 9/25/23 and revised on 11/06/25)." Problem: Resident #18 "is at risk for fluctuations in mood r/t DX of Dementia, PTSD, and Delusional DO [Disorder]. [Resident #18] may continue to experience grief r/t the loss of independence and [his/her] overall physical decline; [he/she] may refer to the facility as a 'prison' or that [he/she] feels 'incarcerated.' Self-reports feeling down/depressed and feeling restless. [Resident #18] may be observed with increased irritability when having increased pain r/t arthritis or if upset with staff r/t care. In 8/2025, [his/her guardian] reported noticing increased episodes of irritability. HX [history] of self-harming behaviors such as hitting [his/her] forehead with a closed fist and making suicidal statements…(initiated 9/25/23 and revised on 9/26/25). One of the interventions noted "If [Resident #18] appears down/sad: Encourage [him/her] to take a walk throughout the facility; Encourage [him/her] to spend time outdoors, weather permitting (initiated 1/19/24 and revised 11/7/24). The "Comprehensive Care Plan" did not include a Care Plan area that addressed the resident's history of/actual elopement in 9/2023; and did not provide guidance for steps that staff could take to monitor for and respond to signs and symptoms of elopement. Review of Resident #18's "Multidisciplinary Care Conference" 5/13/25 revealed the resident's Unit Coordinator/Registered Nurse (RN) A noted that an 'Elopement Risk' review was N/A (not applicable) for the resident. Further review of the document revealed on 5/8/25, Resident #18 was "irritated with staff when nurse called for [him/her], had blankets over [his/her] head when nurse entered [his/her] room. Appeared more melancholy, salty, distrustful, stated it felt like [he/she] was in jail. (Later reported to SW [Social Worker] this statement was a joke.)" Review of Resident #18's Physician's Orders (PO) revealed orders, as follows:

	11/24/25 – Oxycodone Hydrochloride (HCl) five (5) milligrams (mg), one (1) tablet (tab) by mouth (po) three times per day (tid) for Chronic Pain. 9/24/25 – Duloxetine HCl 30 mg, one (1) capsule (cap) po every (q) day (d) for mood. 4/3/25 – Quetiapine Fumarate 25 mg, one half (.5) tab po q day for mood. 1/5/24 – Memantine HCl 10 mg, one (1) tab po twice per day (bid) for Dementia. 11/22/23 – Levetiracetam 750 mg, one (1) tab po bid for Seizures. 5/9/25 – Methocarbamol Oral 750 mg, one (1) tab po bid for pain. Review of Resident #18's Medication Administration Record (MAR) between 10/1/25 through 12/4/2025 revealed that Resident #18's PO for Oxycodone HCl five (5) mg tid was to be administered at 7:00 a.m., 2:00 p.m., and 10:00 p.m. The resident's 10/2025 MAR documented that on 10/1/25, Resident #18 "Refused" the 2:00 p.m. pain medication. The resident's 11/2025 MAR noted that Resident #18 was "Absent from home without meds" for the 2:00 p.m. scheduled dose of Oxycodone on 11/16/25. Resident #18's 12/2025 MAR documented to "See Progress Note" in reference the administration of the 2:00 p.m. Oxycodone HCl on 12/4/25. Continued review of the 12/2025 MAR revealed that on 12/5/25, Resident #18 was documented as having "Refused" his/her 8:00 a.m. scheduled pain medication, Methocarbamol. Resident #18 could not have refused the medication, as there was an active search in progress for Resident #18 at this time. The review of the MARs revealed there was not an identified pattern of Resident #18 missing his/her scheduled pain medication(s). Resident #18's unit's "Member Sign In/Out Log" were reviewed between 11/2025 and 12/2025. Resident #18 was not signed out of the unit/facility on 11/16/25, which was the date the MAR indicated the resident was absent from the home without medications (missed) the 2:00 p.m. scheduled pain medication. Review of this log revealed Resident #18 was signed out of the unit on the following dates: 11/22/25 – Resident #18 signed out of the facility at 12:25 p.m. to go with his/her family. The form did not indicate the time of the resident's return. 11/28/25 – Resident #18 signed out of the facility at 1:02 p.m., and the form did not indicate the time of the resident's return.

	12/4/25 – Resident #18 signed out of the facility to go "outside" at 12:45 p.m. The facility did not provide Sign In/Out Logs prior to 11/2025 for review. Review of Resident #18's "Progress Notes" revealed there was not a note in the record on 11/16/25 that indicated Resident #18 was not on the unit or was absent from the facility without medications when the Oxycodone was scheduled to be administered at 2:00 p.m. The "Progress Notes" reviewed between 8/6/25 and 12/4/25 documented the following: 8/6/25 – Social Services Note – The resident's Patient Health Questionnaire (PHQ) – 2 to 9 revealed a score of four (4) which indicated mild depression. According to the resident, he/she was "feeling down, depressed, or hopeless for two (2) – six (6) days during the assessment period. Resident #18 stated that he/she "has felt down 'a couple of time' but indicated the feelings were 'short-lived'…I'd say I'm more angry than depressed about my situation…but I'm not in a deep depression." The resident stated "it does feel like a type of incarceration at times." 8/11/25 – Social Services Note – The resident's legal guardian/adult child "reported that [Resident #18's] episodes of irritability/frustration seem to have increased in frequency – now occurring a couple of times a month. [The guardian/adult child] stated [Resident #18] will become fixated on things and be difficult to redirect. [The guardian] expressed that [he/she] wanted staff to be aware and to continue to monitor [him/her] at this time." 8/20/25 – Social Services Note – "…SW [Social Worker] inquired about statement made recently to a caregiver about being depressed r/t being at the facility. [Resident #18] reported that [he/she] does not recall saying that. [Resident #18] stated 'I don't hate it here…I just wish I could be somewhere else." 9/28/25 – Health Status Note – Resident #18 "complains of increasing drowsiness, decreased appetite and visual hallucination stating, 'sometimes, I see blankets moving when I sleep" and it started couple of days ago on and off." [sic] 9/28/25 – Behavior Note – Resident #18 "reports [he/she] is very fatigued after [his/her] medication was increased.

	Verbalized sleeping a lot and being drowsy. States [his/her] pain level is the same and has not changed. Also reports [he/she] feels [he/she] is having hallucinations due to seeing [his/her] blankets moving." 9/30/25 – Social Services Note – Resident #18 "was discussed [today] r/t changes with cognition and energy. [Resident #18's confusion and lethargy have increased with changes in antidepressants and pain medications. Staff recently noticed change in cognition." 11/10/25 – Social Services Note – Resident #18 "enjoys spending time independently in [his/her] room, reading, going for walks outside, looking at the big flag, visiting with staff/peers, exercising in the wellness center and attending some activities and trips…Effective Interventions: Plan interventions…if resident appears down/sad: Encourage him to spend time out time outside, weather permitting…" 12/2/25 – Long Term Care Evaluation – "Mental Status:…Level of cognitive impairment: Moderate impairment (memory loss). Mental Status Note: Due to [his/her] memory issues, [he/she] has a guardian at present…Mood & Behavior Note: [He/She] has history of attempted suicide. Currently, [he/she] denied any suicidal ideation. Currently, [he/she] is on psychotic medication." 12/4/25 at 3:17 p.m. – "Orders - Administration Note" – Oxycodone HCl five (5) mg, give one (1) tab po tid for Chronic Pain noted "Member off unit." On 12/9/25 at 12:36 p.m., an interview was conducted during the Initial Tour of the facility with Resident #18's Unit Coordinator/Registered Nurse (RN) A. RN A said that he/she did not know if Resident #18's incident was considered elopement. The nurse said around 2023, Resident #18 went through a period of decreased cognition which resulted in the resident leaving through a gate in the courtyard area on an open unit, and the facility determined that was elopement. RN A said that after that elopement incident, Resident #18 was transferred to the secured unit, and resided on that unit for a short time before returning to his/her current open unit. He/She said that Resident #18 experienced a lot of back and hip pain, so his/her walking routine was flexible according to his/her pain level, and the resident completed short walks. RN A said the resident signed in and out each time he/she went for a walk, and the nurse was not aware if there was a pattern; and did not know the average period the resident would be gone. The expectation

	was for nursing staff to contact the doctor when there was a missed medication. RN A said that Resident #18 usually walked the grounds in the nature trail and the resident loved to walk to the cemetery on the grounds. RN A stated he/she was not aware of Resident #18 going off facility grounds on his/her walks. Continued interview with RN A revealed that on 12/4/25 around 5:00 p.m., he/she was informed that Resident #18 was missing, and staff searched for him/her in the gym and laundry room. Resident #18 was not located, and it was then the 'Missing Member Elopement Protocol' was started and the search for Resident #18 continued off facility grounds. The nurse said that the police were contacted around 7:00 p.m. RN A said he/she was not sure if Resident #18 had a Care Plan for elopement and did not think the resident had any mental health crisis going on. However, RN A said that Resident #18's legal guardian/adult child reported that Resident #18 was starting to hide things and was becoming a little more paranoid. In a follow-up interview on 12/9/25 at 1:32 p.m. towards the end of the Initial Tour, RN A was asked to provide the last six (6) months of the unit's Sign In/Out sheets, and the nurse stated that he/she did think they kept the old Sign In/Out sheets. During the interview, it was determined that there were Sign In/Out sheets available to review for 11/2025 and 12/2025. During an interview on 12/9/25 at 3:18 p.m., the facility's Director of Nursing (DON) said Resident #18 wasn't going outside as much during the cold weather and usually walked for one (1) to two (2) hours – that was his/her pattern. The DON said the resident did not stay outside as long when it was cold. When staff looked for him/her around 3:00 pm in his/her room, they saw that his/her bed was stripped. The facility tried to call Resident #18 around 5:00 p.m. and it was then the facility realized the resident did not have his/her cell phone with him/her that day. A "Member Search" was started around 5:00 p.m. The DON said that the facility did not consider the incident as an elopement as Resident #18 was not assigned one (1) to two (2) hour checks. Resident #18 had a suicide attempt on 1/1/24 when the resident tied shoelaces around his/her neck and was found in a linen closet. The DON confirmed Resident #18 eloped from the courtyard in 9/23 and said that during that time the resident's cognition was impaired but Resident #18 had since improved.

	In a telephone interview on 12/10/25 at 11:57 a.m., Resident #18's legal guardian/adult child had the understanding that when whether conditions were too cold, Resident #18 was to walk inside the building. He/She said that he/she did not consider 26 degrees to be too cold for Resident #18 to go for a walk outside. An interview was conducted with CNA H on 12/10/25 at 12:25 p.m., and the aide said Resident #18 went on walks inside or outside the building three (3) to four (4) times during the week, and that usually staff or a family member was with him/her. Outside of the building, Resident #18 walked around outside to the facility's nature trail and cemetery. At the most, Resident #18 would be gone up to two (2) hours before needing a break. The aide said that nursing staff were to perform a location check on the residents every two (2) hours and if Resident #18 was gone for two (2) hours, a location check should be done. On 12/10/25 at 12:33 p.m., in an interview, CNA G said he/she worked regularly with Resident #18 and was aware of his/her prior suicide attempt when he/she was missing and staff found the resident in a closet. CNA G said that during the summer months, Resident #18 walked almost every day, and was outside for 15 minutes up to an hour during the walks. CNA G said the resident was only gone for three (3) to four (4) hours when he/she went out with his/her family. Continued interview revealed that CNA G was not aware if Resident #18 had any prior elopement attempts. The aide said that he/she prompted the resident to get his/her glasses when Resident #18 signed out on 12/4/25, and he/she dismissed the prompt for him/her to get his/her glasses which tracked the resident's location. CNA G said that Resident #18 usually remembered the glasses all of the time. At 3:00 p.m., CNA G noticed that he/she had not seen Resident #18 and went to the laundry room to locate him/her. The resident was not in the laundry room and CNA G did not mention this to other nursing staff, at that time. LPN K mentioned Resident #18 was not present for the dinner meal, and a member search was initiated; an "elopement" of member was announced; and police were notified. Interview on 12/10/25 at 1:10 p.m. with LPN C revealed that a missing medication should prompt him/her to conduct a location check for a resident. The nurse was not familiar with any orders or guidance that provided instruction on the type of weather that would prevent Resident #18 from walking outside (too hot, too cold, rainy, etc.); and how the resident would be redirected to walk inside when the weather did not support the resident in

	doing so and how the resident would be monitored, if he/she still choose to do so. Interview on 12/10/25 at 1:25 p.m. with LPN D revealed the nurse was familiar with Resident #18 and routinely provided the resident care and services. LPN D said that when Resident #18 went for walks, he/she signed out, informed staff, and was usually back within an hour or two (2). LPN D said that he/she was not working in the facility on 12/4/25; however, the nurse said that if he/she had been passing medications, he/she would have looked for Resident #18 at 2:00 p.m. and again at 3:00 p.m.; and if he/she had been unable to locate the resident, LPN D would have contacted the facility's Assistant Director of Nursing (ADON). LPN D said that on 12/4/25, it was 26 degrees Fahrenheit (F) and very cold outside. LPN D said that he/she remembered because he/she was cold while bundled up and working outside at home that day. LPN D was familiar with Resident #18's history of Depression, suicide attempt, and diagnosis of Dementia. LPN D said that when he/she spoke with Resident #18 during his/her shift on 12/3/25, LPN D mentioned to Resident #18 how cold it was going to be [the following day]. At that time, LPN D observed eight (8) blankets on the resident's bed. The nurse said Resident #18 was always cold; and said the resident wore his/her glasses most of the time. During the Daily Briefing conducted on 12/10/25 at 4:10 p.m., the facility's Administrator stated that he/she and Resident #18's legal guardian/adult child believed that Resident #18 completed an act of self-harm/suicide. In a follow-up telephone interview with Resident #18's legal guardian/adult child on 12/11/25 at 3:25 p.m., with RN A and the facility's Licensed Master Social Worker (LMSW) present, Resident #18's guardian said "[he/she] was never gone for very long" in reference to the walks the resident took outside on facility grounds. Resident #18's guardian confirmed that he/she thought Resident #18 carried out a plan to harm him/herself. The guardian said that when viewing the camera from the time the resident walked out of the building, he/she was wearing a coat that the guardian did not recognize. It was not a pattern for Resident #18 to leave his/her bed unmade, or to leave his/her glasses and/or cell phone when he/she went out on walks.
§ 51.120 (m) (1) Unnecessary drugs (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:	Based on observations, interviews and record reviews, the facility failed to provide the necessary care and services for one (1) resident (Resident #6) to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, the facility failed to administer three (3) medications as ordered by the physician.

(i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above. **Rating** – Not Met **Scope and Severity** – D **Residents Affected** – Few	The findings include: Review of the policy titled "Clinical Services & Quality of Care Medication Administration" last reviewed on 2/20/25. The policy read in part: "Policy - Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the provider and in accordance with professional standards of practice, in a manner to prevent contamination or infection. GUIDELINES - Policy Interpretation and Implementation… 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the provider's prescribed parameters…15. Administer medication as ordered in accordance with manufacturer specifications…21. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR…26. Medication timing (excluding insulin) is home-specific, and the time schedule will be provided by the home." Resident #6 was admitted to the facility on 7/23/24 with diagnoses that included Chronic Kidney Disease, Hemiplegia and Hemiparesis following other Cerebrovascular Disease Affecting Left Non-dominant Side, Dysarthria following other Cerebrovascular Disease, Chronic Kidney Disease, Need for Assistance with Personal Care, Unspecified Dementia, Essential Hypertension, Hypotension, and Tachycardia Disease. Review of the quarterly Minimum Data Set (MDS) dated 10/13/25 identified the Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated the resident was cognitively intact. Review of the Order Summary Report included the following medications: -Start date 10/21/25 Midodrine HCl (Hydrochloride) Tablet 5 MG (milligram) Give one (1) tablet by mouth one (1) time a day every Mon., Wed., Fri. for Hypotension Related to hemodialysis **Hold if SBP (systolic blood pressure) greater than 115. -Start date 10/22/25 Isosorbide Mononitrate ER (Extended Release) 24 Hour Oral Tablet 30 MG Give one (1) tablet by mouth in the afternoon for Cardiac Output Do not Crush HOLD if SBP <(less) than110. -Start date 10/21/25 Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Give 0.5 tablet by mouth at bedtime for coronary artery disease *** Hold if SBP less than 110 or HR (heart rate) less than 60.

	Review of the MAR and Vital Record for High Blood Pressure for December 1-12, 2025 revealed the resident was administered Midodrine HCl Tablet on: 12/3/25 with no record of vital signs prior to administration. 12/5/25 vital signs were above the parameters at 135/70 and should have been held. Isosorbide Mononitrate ER Oral Tablet was administered on: 12/1/25 vital signs were below parameters at 104/61 and should have been held. 12/9/25 no vital signs were obtained and medication was administered. Review of the MAR for November 1-30, 2025 and Vital Record for High Blood Pressure revealed the resident was administered Midodrine HCl Tablet on: -11/21/25 vital signs were above the parameters at 127/53 and should have been held. Isosorbide Mononitrate ER Oral Tablet was administered on: 11/1/25, 11/2/25, 11/4/25, 11/6/25, 11/8/25, 11/9/25, 11/12/25, 11/15/25, 11/16/25, 11/18/25, 11/20/25, 11/20/21/25, 11/22/25, 11/25, 11/27/25, 11/29/25, and 11/30/25 without vital signs documented prior to administration. 11/4/25 vital signs were 102/49 and medication was administered. 11/19/25 vital signs were 109/52 and medication was administered. 11/24/25 vital signs were 108/54 and medication was administered. Metoprolol Succinate ER Tablet was administered on: 11/1/25, 11/2/25, 11/3/25, 11/6/25, 11/7/25, 11/15/25, 11/21/25, 11/24/25, 11/25/26, 11/26/27, and 11/27/25 without vital signs documented prior to administration. During an interview on 12/12/25 at 9:30 a.m., Licensed Professional Nurse (LPN) E stated medication that required vital signs prior to administration were obtained by the Certified Nursing Aides (CNAs) and the vital signs were automatically entered into the electronic medical records. When asked when the vital signs were taken prior to medication administration, LPN E said, “I would say at least an hour.” He/she stated they would use the blood pressure taken that morning. He/she stated the computer told them (licensed nurses) when to obtain the blood pressure. LPN E reviewed the vital signs for Resident #6 for 12/9/25 and stated the resident’s blood pressure was obtained at 7:24 a.m. and was 128/51. He/she stated the time was not close enough to 11:00 a.m. to administer the Isosorbide Mononitrate ER Oral Tablet without obtaining the resident’s

	blood pressure again. He/she reviewed the Physician Order again and stated the medication had to be held if systolic was less than 110. LPN E stated the resident's blood pressure should have been obtained every day before the medications were administered. He/she stated it was important to obtain vital signs prior to medication administration because they did not want the residents' blood pressure to drop too low. During an interview on 12/12/2025 at 10:21 a.m., Registered Nurse (RN) B stated the nursing staff followed the Computerized Physician Orders (CPO) in the electronic medical record. RN B explained the process to administer medication as following the CPO from the physician, they wrote the order, the nurse confirmed the order, then the nurse followed the MAR so they could carry out the order. If the order stated if systolic is less than 110 then hold, the blood pressure should have been taken about an hour before administration. He/she stated the medication should not have been administered if they did not have a current blood pressure reading. RN E stated it was important to follow the Physicians' Orders to maintain baseline for residents and to make sure vital signs were in range to manage treatment.
§ 51.190 Infection control. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. **Rating –** Not Met **Scope and Severity –** E **Residents Affected –** Some	Based on observation and interview, the facility failed to ensure medical and/or treatment supplies were discarded when the sterility of their packaging became compromised or they were kept past the manufacturer's expiration date. This was true for two (2) of four (4) medication storage rooms observed (Holland Lighthouse and Grand River). This practice had the potential to affect any resident requiring the use of these supplies who resided on these two (2) units, with a combined census of 32 residents on the first day of the survey. The findings include: 1. An observation of the medication storage room on the Holland Lighthouse unit began at 3:02 p.m. on 12/11/25. This observation occurred in the presence of the Director of Nursing (DON). The following items were found in the cabinets of the storage room: - Five (5) VanishPoint ® 3 milliliter (mL) syringes with a manufacturer's expiration date of "2025-11-28"; - One (1) Prevent ® G Safety Winged Blood Collection Set with a manufacturer's expiration date of "2025-07-28; and - One (1) package of Steri-Strip™ Reinforced Skin Closures with a manufacturer's expiration date of "2025-06".

	An observation of the contents of the treatment cart stored in the medication room found the following in a box of single use packets of Hibiclens ® Antiseptic/Antimicrobial Skin Cleanser with a manufacturer's expiration date of "2025/04": - Thirty-one (31) single use packets of Hibiclens ® with expiration dates of "2025/04"; - Three (3) single use packets of Hibiclens ® with expiration dates of "2025/06"; - One (1) single use packet of Hibiclens ® with an expiration date of "2025/08"; and - Four (4) single use packets of Hibiclens ® with expiration dates of "2025/10". The DON verified the above findings at the time of discovery, and at 3:27 p.m. on 12/11/25, the DON confirmed these items had been kept past their expiration dates. 2. An observation of the medication storage room on the Grand River unit began at 3:29 p.m. on 12/11/25. This observation occurred in the presence of the DON. The following items were found in the treatment cart stored in the medication room: - Twenty (20) packs of Povidone-Iodine Swabsticks with expiration dates of "2024-05-20"; and - Three (3) packets of NitriDerm ® Sterile Gloves with expiration dates of "2025-11-28". The DON verified the above findings at the time of discovery, and at 3:37 p.m. on 12/11/25, the DON confirmed these items had been kept past their expiration dates. The DON stated his/her expectation was that nurses were to regularly review the expiration dates of medical supplies and remove anything that had expired, and he/she referred to the facility's policies regarding "Medication Administration" and "Medication Labeling and Storage". Review of the policies referenced by the DON found nothing addressing expired medical and/or treatment supplies. During follow-up communication at 5:54 p.m. on 12/11/25, the DON reported the facility did not have a policy that discussed expired medical supplies, and he/she restated his/her expectation was that nurses were to regularly review the expiration dates of medical supplies and remove from use anything that had expired.

§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code, and NFPA 99, Health Care Facilities Code. **Rating** – Not Met **Scope and Severity** – D **Residents Affected** – Few	**<u>Smoke Barriers and Sprinklers</u>** Based on observation and interview, the facility failed to maintain the sprinkler system. The deficient practice affected one (1) of ten (10) smoke compartments in the main building, with no residents. The facility had the capacity for 128 beds with a census of 118 on the first day of the survey. The findings include: Observation during the building inspection tour of the kitchen, on 12/11/25, at 1:40 p.m., revealed that the fragmentable glass bulb sprinkler heads installed in the walk-in cooler and the walk-in freezer were loaded with gray fuzzy foreign material consistent with dust and not replaced, as required by section 5.2.1.1.1 and 5.2.1.1.2(5) of NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview with the Administrator, on 12/11/25, at 1:30 p.m., revealed that the facility was not aware that the sprinklers were loaded with foreign materials. The census of 118 was verified by the Administrator on 12/9/25, at 9:00 a.m. The finding was acknowledged by the Administrator and verified by the Director of Engineering during the LSC exit interview on 12/12/25, at 2:30 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.5 Extinguishment Requirements.** **19.3.5.1** Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. **9.7.1.1 *** Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: **(1)** NFPA 13, Standard for the Installation of Sprinkler Systems **9.7.5 Maintenance and Testing.** All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. **Actual NFPA Standard: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011)** **5.2.1 Sprinklers.**

	5.2.1.1* Sprinklers shall be inspected from the floor level annually. **5.2.1.1.1*** Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). **5.2.1.1.2** Any sprinkler that shows signs of any of the following shall be replaced: **(1)** Leakage **(2)** Corrosion **(3)** Physical damage **(4)** Loss of fluid in the glass bulb heat responsive element **(5)*** Loading **(6)** Painting unless painted by the sprinkler manufacturer agent, unless otherwise allowed by the design of the fire extinguishing system.