STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235008	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Lawn Medical Care Facility	50 Sanderson Lane Coldwater, MI 49036

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 0689 Level of Harm - Actual harm Residents Affected - Few	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 implement interventions to prevent accidents for two residents (#2, #6) of three resident reviewed for accidents resulting in major injury (fracture and brain bleed) and hospitalization for resident #2.Findings Included: Resident #2 Review of the medical record demonstrated R2 was admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), dementia, repeated falls, constipation, psychotic disorder with delusion, hypothyroidism (low thyroid hormone), vitamin D deficiency, chronic kidney disease, depression, gastro-esophageal reflux, osteoarthritis (arthritis that occurs when flexible tissue at the end of bones wears down), chronic pain, hyperlipidemia (high fat content in blood). Review of the medical record revealed a recent hospital leave on 06/30/2025 and a readmitted on [DATE] with new diagnoses that included displaced fracture of lateral end of left clavicle, intercranial injury, and fall on same level. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) for 07/28/2025 revealed a Brief Interview for Mental Status (BIMS) 7 (severe cognitive impairment) out of 15. Review of the medical record revealed progress note 06/30/2025 at 09:15 (a.m.) Note Text: (Physician name) made aware of resident fall, hematoma to L lateral head, pain to L shoulder/neck, and discoloration/lack of ROM to L arm. DRR completed, new order received: Send to ER for eval and treat.Call placed to (name of ambulance company) at 0847.EMS arrived at 0855. R2's medical record also revealed progress note 06/30/25 at 10:46 (a.m.)Note Text: Called to residents room by staff at approx. 830am, resident was noted laying on bathroom floor on right side with head near toilet and feet near the door. Upon assessment resident noted with skin tear to L elbow approx. 0.5cm in diameter, LUE noted discoloration to length of arm. Area was cleansed with NS pat dry and CDD applied. Resident also noted with hematoma to L side of head measuring approx. 5cm in diameter. Resident denied pain at first, but when trying to move LUE resident c/o pain to neck and shoulder. HS called and down to assess. Unable to assess residents other extremities at this time d/t going to hospital. Neurological assessment WNL for resident. VS: 97.5, 66, 22, 111/60, 90%RA. BG. 138. Review of R'2s medical record revealed a progress note 07/03/2025 at 15:43 (03:43): Received report from (nurse at hospital). Resident admitted to hospital with a brain bleed (has resolved), and left clavicle fracture. Review of R2's plan of care revealed a problem statement written 04/7/2025 which stated: I am at a (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	risk for falls r/t impaired mobility, incontinence, hx of falls at home, diagnosis' (dementia, CVA), potential medication adverse effects (antidepressant, antiplatelets, antiHTN, diuretic). I am impulsive (sp) and self-transfer despite reminders/education which increases risk. R2's care plan also revealed a written intervention with an initial written date of 04/7/2025 I need a safe environment with non skid footwear, paddle call light left within reach, FWW left within reach, safety frame to toilet, bed control out of my reach, facility WC with anti roll back, B standard footrests and standard cushion, Wide bed with Raised perimeter overlay to mattress, Safety reminder sign to bed side table. Safety reminder sign to bedside wall. Res. to have fan on in room as tolerates. Res. to have urinal at bedside. Safety reminder sign to FWW. Low to floor bed with fall mat. My preferred method of transfer from bed is to put knee's onto bedside mat prior to getting up. **15 Minute checks** . Review of provide incident report revealed R2 was found on the floor on 06/30/2025 at 08:30 a.m. and had experienced an unwitnessed fall. The same incident report included a section entitled, any other information or specific factors that may have contributed to this fall? which revealed, 15 min checks not done during time. The same incident report included a section entitled, root cause of fall, which stated, Poor safety Awareness. During an interview on 08/27/2025 at 01:04 p.m. Director of Nursing (DON) B reviewed the facility investigation file regarding R2's fall on 06/30/2025. She explained that the root cause of R2's fall was reviewed by the Interdisciplinary team and was to be determined that the cause was R2's poor safety awareness and lack of interventions that had been implement that were listed on his plan of care. DON B explained that disciplinary action had been conducted because 15 min check had not been completed, as specified on the plan of care, since 07:45 a.m. and the fall occurred at 08:30 a.m. DON B provided a document entitled Written Record of Written Warning that had been provided to Certified Nursing Aide (CNA) H. The same document revealed the name of CNA H, the date of 06/30 and stated Summary of event and education provided to staff member(s): Staff to make sure to follow care plan & 15 min checks. If unable , to communicate with staff on hall so we can do the check. *3 day suspension. On 08/27/2025 02:37 p.m. during an attempted interview R2 was observed lying down in bed. It was observed that his bed was against the wall, a perimeter mattress was in place, the bed was in a low position, a fall mat was on the floor next to his bed and his pressure pad call light was within reach. Resident did not respond to verbal stimuli and appeared to be sleeping. During a telephone interview on 08/27/2025 at 02:43 p.m. Certified Nursing Aide (CNA) H explained that she had been providing care to R2 on the date of 06/30/2025. CNA H explained that she was in a room assisting another resident when she was notified that R2 was found on the floor. CNA H explained that she had last completed R2's 15-minute checks at 07:45. CNA H explained that she had been received disciplinary action for not following R2's plan of care and had also received a 3-day suspension. Resident #6 (R6) Review of the Resident #6 (R6) clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed Resident #6 (R6) had long and short-term memory impairment and severely impaired decision-making skills for daily living. R6 was admitted to the facility with diagnoses that included dementia and resided in the facility secure unit. On 08/25/2025 10:54 AM, R6 was observed in the facility's secured memory care unit, attending a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	music program. A large purple bruise was observed to R6's right eye, along scrap/small abrasion to the nose. On 08/25/2025 at 11:37 AM, during a phone interview with R6's representative, family member L reported being made aware that R6 fell on 8/21/25 while walking with a new Certified Nursing Assistant (CNA.) but was not exactly sure or how the fall occurred. On 08/26/2025 at 10:27 AM, video footage of R6's fall was observed in the Nursing Home Administrator (NHA) A office with NHA A and DON B present. NHA A explained the CNA on camera walking with R6 was a high school student and part of the OJT, NHA A explained OJT stood for On the Job Training, and the local high school had a career center program and the facility hired from there. The camera footage showed unidentified CNA from the OJT program standing with R6 holding R6's hand and touching residents' side, resident wearing a gown no gait belt was in place. The footage showed R6 by the dining room/living room area and slowly R6 turned and fell. DON B was queried at that time if the facility used gait belts DON B said yes. When queried if R6 was to have a gait belt on while ambulating DON B said yes and the CNA from the OJT had since been educated. Review of R6's care plans did not have the use of a gait belt as an intervention for fall prevention or care. On 08/26/2025 at 1:48 PM, during an interview with DON B she reported the use of a gait belt was not implemented on a care plan because it was standard of practice and the expectation. On 8/26/25 at 2:20 pm during an interview with CNA M she reported R6 ambulated very slowly with no devices (walker, cane) but staff were to always make sure a gait belt was used. When queried if that was something new, CNA M stated no they aways had to use a gait belt with R6. Review of the incident report dated 8/21/25 revealed R6 was ambulating with staff, and a gait belt was not in use at the time of the fall. R6 sustained a 4 by 3-centimeter hematoma and a bump to the right-side of the forehead. The section of the form titled Root Cause was left blank, the section of the form title intervention the box staff education was marked and in all capital, letters read MUST SPECIFY of note, there was no specific education listed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on observation, interview and record review, the facility failed to provide notice of discharges and transfers, to the representative of the Office of the State Long-Term Care Ombudsman.According to an email from the Long-Term Care Ombudsman, received on 8/22/25, the facility had not been sending notices for transfers and discharges and that they did not have any notices on record for 2024 or 2025.On 8/26/25 at 12:03 PM, the Nursing Home Administrator (NHA) was asked who is responsible for notifying the ombudsman of discharges and at 12:32 PM NHA reported that the ombudsman is emailed on a monthly basis either by herself or by the social worker. When asked to provide the monthly emails dating back to their last annual survey, NHA reported that they only had 2 on file. Those emails were provided and were dated 8/14/25 and 8/26/25.On 8/27/25 at 2:25 PM NHA was asked if the facility had a policy related to Ombudsman notification and at 2:36 PM NHA reported that they do not have a written policy regarding Ombudsman notification.On 8/27/25 at 2:39 PM, during an interview with Social Service Director (SSD) N, they reported that they were responsible for notifying the Ombudsman of discharges and transfers. SSD N further reported that notification should be done monthly. When asked if that had been occurring SSD N reported that it is sometimes done. When asked why it wasn't done consistently each month, they reported that they forget.

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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 observation, interview and record review, the facility failed to ensure clinical rationale was documented by the provider for ongoing use of an as needed (PRN) anti-anxiety medication beyond 14 days, for one resident (resident #6) of four residents reviewed.Findings include: Review of the clinical record revealed R6 was admitted to the facility on [DATE] with diagnosis of that included Alzheimer's dementia. R6 's Minimum Data Set with an Assessment Reference Date (ARD 5/24/25 reflected R6 had long and short-term memory impairment and severely impaired cognitive skills for daily decision making. Further review of the clinical record reflected R6 was prescribed Ativan on 7/25/25 0.5 milligrams as needed three times a day for restlessness and anxiousness, a urinalysis was also ordered R6 on 7/25/25 and an anti-biotic was ordered on 7/26/25. Further review of the clinical record did not include rationale from the Physician/ provider for continued us of the PRN Ativan beyond 14 days of the mediation being ordered. On 08/26/2025 9:57 AM, during an interview with the Director of Nursing (DON) B the concern of the ongoing use of the PRN Ativan was discussed and DON B stated the facility still used paper charts as well. Review of the hard/paper copy of R6's medical record contained a most recent visit by Psychiatry on 2/6/25 and a Physician visit dated 6/26/25. On 08/27/2025 10:25 AM, during an interview with Social Worker (SW) K she reported that the Nurse contacted the Physician on 7/25/25 regarding R6 having increased agitation/restlessness and that was why the Ativan was ordered PRN, when queried why there was no stop date for the Ativan SW K stated she was not sure, but R6 had a lot of anxiety and agitation. When quired about R6 simultaneously having had a urinalysis done on 7/25 and an antibiotic prescribed the following day to treat a urinary tract infection, it was asked of the infection could cause or contribute to agitation/restlessness. SW K responded that R6's family member got married in the facility's courtyard on 8/8/25 and the family member wanted R6 to be able to participate in the wedding but was now considering comfort care. A request for documentation from the attending physician/prescribing practitioner for rationale to extend the use of the Ativan was requested and not received by the end of the survey. A follow up interview was conducted with DON B who reported the Ativan continued beyond 14 days due to the family member getting married and now that that has occurred R6 will now be changed to comfort care, and the Ativan order will change.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on observation, interview, and record review the facility failed to complete a Significant Change in Status Assessment (SCSA) for one resident (#91) of 15 resident's Minimum Data Set (MDS) reviewed.Findings Included:Resident #91 (R91)Review of the medical record demonstrated R91 was admitted to the facility 01/31/2025 with diagnoses that included atrial fibrillation, hypothyroidism (low thyroid hormone), gastroesophageal reflux, chronic pain, sacral pressure ulcer, osteoarthritis (arthritis that occurs when flexible tissue at the end of bones wears down), hyperkalemia (high level of potassium in blood), bradycardia (heart rate below 60 beats per minute), history of pace maker, and urinary retention. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/07/2025 revealed a Brief Interview for Mental Status (BIMS) of 13 (cognitively intact) out of 15. Review of R91's medical record revealed that an Unstageable pressure wound to his coccyx had been identified on 07/10/2025. The most recent completed skin evaluation completed on 08/25/2025 revealed that the coccyx wound had progressed to a stage 4. Review of the medical record revealed R91 had a recorded weight (wt) of 168 lbs. (pounds) on 07/03/202 and a recorded weight of 153 lbs. on 08/07/2025. Review of progress notes dated 08/25/25 revealed: Note Text: WT:153# (8/7) wt. is down 9% x 30 days, down 16% x 90 days & down 15% x 180 days.Review of the most recent completed MDS (quarterly MDS), with an assessment reference date (ARD) of 08/07/2025, revealed section M-Skin Conditions was documented as having one unstageable pressure ulcers. Review of section K-Swallowing/Nutritional Status, with the same ARD, revealed documentation that R91 had greater than 5% weight loss in the last 30 days.Review of R91's Minimum Data Set history did not demonstrate that the facility had completed a Significant Change in Status Assessment (SCSA). Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1 dated October 2024 revealed Some Guidelines to Assist in Deciding if a Change is Significant or not: Decline in two or more of the following: .-Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days). -Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status.In an interview on 08/26/2025 at 10:58 a.m. MDS Nurse D was asked review R91's last MDS, with an ARD of 08/07/2025. MDS Nurse D confirmed that the quarterly assessment revealed that R91 had an unstageable pressure ulcer and a 5% weight loss in the last 30 days. When asked why a Significant Change in Status Assessment (SCSA) MDS was not completed, MDS Nurse D could not explain why it had not been completed.