STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235009	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornapple Manor	2700 Nashville Rd Hastings, MI 49058

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 This citation pertains to intake MI00147758. Based on interview and record review, the facility failed to recognize and report an injury of unknown origin for 1 (Resident #101) of 3 residents, reviewed for reporting, resulting in the lack of reporting and the potential for a delay in the investigation. Findings include: Resident #101 Review of an Admission Record revealed Resident # 101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of Resident #101's Progress Note dated 10/28/24 at 4:10 PM revealed, Nurse was called to (Resident #101) room by staff member, noted a 9.5 cm x 9 cm bruise to right bicep. (Resident #101) is unable to describe what happened, but states It hurts, it hurts!. Order placed to monitor for s/sx (signs and symptoms) of infection x 5 days. Review of Resident #101's Progress Note date 10/28/25 AT 11:15 PM revealed, (Resident #101) is being monitored r/t (related to) bruise noted on bicep. S/s of pain noted as (Resident #101) was observed cradling and protecting area as well as when asked if she was hurting (Resident #101) violently nodded head and said yes. Swelling at the site is noted but (Resident #101) was not well compliant with allowing staff to fully inspect area. No signs of worsening condition of the bruise. Some noted swelling to the arm itself during visual assessment. (Resident #101) would not allow staff members to do a physical assessment. Scheduled pain medication administered, and (Resident #101) informed she could have prn (as needed) administration if needed . Review of Resident #101's Progress Note dated 10/29/24 at 1:06 PM revealed, Bruise has spread from right arm to chest. (Resident #101) continues to guard arm and been given PRN Morphine (pain medication) in between scheduled doses. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #101's Progress Note dated 10/29/24 at 7:00 PM revealed, CNA'S (Certified Nursing Assistant) called the nurse to room . A 5 cm (centimeters) x open area on rt (right) of neck, 0.3 cm open area on left side of neck. Open area on left side of neck 1 cm. A bruise on left jaw 1 cm x 1 cm. Redness to left side of neck. Bruise to right top of hand 4.5 x 4 cm, with swollen fingers. Left lower extremity below knee is swollen. Bruises to third and fourth toe and to right third toe. Bruise to right elbow measuring 4 cm x 4 cm. (Resident #101) is unable to give a description as to what happened. (Resident #101) assessed for pain and other injuries. No other injuries noted at this time. The ADON (Assistant Director of Nursing) and DON (Director of Nursing) as well as Social Work. (Resident #101 Family Member) notified. Statements gathered from all staff present at that time that provided care, and changed to a 2 person assist at all times per DON. Review of Resident #101's Progress Note dated 10/30/24 at 3:29 PM revealed, Bruise on toes has spread to left foot. Swelling on left lower extremity under knee is bruising. (Resident #101) continues to be painful with arm guarding and facial grimacing . Review of Resident #101's Progress Note dated 10/30/24 at 4:41 PM revealed, Bruise noted to bottom of left foot. 4.5 cm x 4 cm. Review of Resident #101's Progress Note dated 10/30/24 at 5:57 PM revealed, Resident #101 passed away at 1702 (5:02 PM). Review of Resident #101's Progress Note dated 10/31/24 at 8:56 AM revealed, Following my arrival for shift I was joined by (Hospice Nurse E) to be made aware that (Resident #101's Power of Attorney) requested an examination of (Resident #101) and that a Medical Examiner would be coming to complete an assessment . During an interview on 11/14/24 at 10:37 AM, Licensed Practical Nurse (LPN) H revealed that she had been notified by a CNA after lunch on 10/28/24 that Resident #101 had a bruise. LPN H reported that she noted that the bruise was on Resident #101's inner arm and was about 9 x 9.5 cm. LPN H reported that she reported that Resident #101 was complaining of pain and that Resident #101 continued to yell out that her arm was broken. LPN H reported that she immediately reported the bruise to the DON B , ADON C, and social worker. LPN H reported that she had no idea how Resident #101 had obtained the bruise on her right arm. During an interview 11/14/24 at 2:10 PM, CNA O reported that she had observed bruising on Resident #101's toes and scratches on her neck when she and CNA J went to assist Resident #101 in the afternoon. CNA O reported that she immediately reported Resident #101's scratches and bruises to LPN Q who then came to assess Resident #101. CNA O confirmed that she witnessed DON A and ADON B come down to assess Resident #101. CNA O reported that she had not observed Resident #101 with bruising to her feet or scratches to her neck prior to the observation made on 10/29/24 in the afternoon. CNA O reported that she did not know how Resident #101 obtained the bruises or scratches. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 2:34 PM, CNA J reported that she and CNA O had cared for Resident #101 in the afternoon. CNA J reported that when she and CNA O were laying Resident #101 down, she noted that Resident #101 appeared to be in a lot of pain. CNA J reported that Resident #101 had scratches on her neck that looked fresh. CNA J reported that she also noticed that Resident #101's knee was very swollen, and that her knee had not looked swollen earlier in the day. CNA J reported that she also noted bruising on Resident #101's toes on both of her feet. CNA J reported that she did not know how Resident #101 had obtained the bruises or scratches, but she thought it happened in between lunch and dinner, as she did not note any bruises or scratches on Resident #101 earlier in the day. CNA J confirmed that she reported the bruising and scratches she found on Resident #101 immediately to LPN Q. During an interview on 11/14/24 at 12:01 PM, LPN Q reported that she had been notified by CNA's on 10/29/24 that Resident #101 had bruising and scratching that she did not have earlier that day. LPN Q reported that she first noticed bruises on Resident #101 toes, so she completed a full skin assessment and noted scratches on each side of Resident #101's neck, a bruise on the right side of Resident #101's jaw that was dark purple in color and an another area that was starting to bruise on the left side of Resident #101's jaw. LPN Q reported that she also noticed a bruise on the top of Resident #101's hand, and bruising on both of Resident #101's toes that were dark blue to purple in color. LPN Q reported that Resident #101's fingers were also swollen in between her index finger and her thumb on her right hand and that her left lower leg below her knee was also swollen. LPN Q reported that she immediately reported her assessment to the DON B and had all staff working that day with Resident #101 write statements. LPN Q did not know how Resident #101 had obtained the scratches or bruises on her body. During an interview on 11/14/24 at 3:17 PM, LPN P reported that she had been informed by LPN Q that Resident #101 had a bruise on her arm and that the facility did not know how Resident #101 had obtained the bruise. LPN P reported that she had observed the bruise on Resident #101's arm and that the bruise had spread to Resident #101's chest. LPN P reported that Resident #101 was in a lot of pain, and would not allow LPN P to touch her arm. LPN P reported that when she returned to work on 10/29/24 she had learned from LPN Q that new bruises and scratches were discovered on Resident #101. LPN P reported that when she went to assess Resident #101, and that Resident #101 was experiencing a significant amount of pain, so she contacted Resident #101's hospice nurse and requested that he come assess Resident #101. LPN P reported that Hospice Nurse (HN) E came to the facility on [DATE] to assess Resident #101's bruising and swelling, and made the decision to increase her pain medication to keep her more comfortable. LPN P reported that she had observed swelling on Resident #101's right hand and left leg, bruising on both feet and toes which was fresh purple in color and swelling in the left knee. LPN P reported that DON A had observed Resident #101 that evening, and informed LPN P that she thought Resident #101 was experiencing mottling (A skin condition that occurs when blood flow to tiny vessels under skin is disrupted). LPN P reported that she also worked on 10/30/24 after Resident #101 had passed away. LPN P reported that HN E had returned to the facility and spoke with Resident #101's family member. LPN P reported that HN E had informed LPN P that Resident #101's family member had requested a medical examiner assessment of Resident #101. LPN P reported that HN E remained at the facility with a police officer until the Medical Examiner arrived and the facility released Resident #101's body to the Medical Examiner. LPN P was not able to report how Resident #101 had obtained bruises and scratches. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/24 at 8:36 AM, HN E reported that he had been contacted by LPN P on 10/29/24 and asked to come to the facility and assess Resident #101 for the new bruises, scratches and uncontrolled pain that Resident #101 had. HN E reported that he noted that Resident #101 was in a lot of pain and appeared very uncomfortable. HN E reported that he noted lacerations on both sides of Resident #101's neck. HN E reported that the laceration on the right side of Resident #101 neck was 3 centimeter long and 1 centimeter long on the right side. HN E' reported that Resident #101 had bruising noted on her right upper arm and across her chest, bruising and swelling on her right hand, swelling and bruising on her left knee and bruising on the third toe on both of her feet. HN E reported that he was very concerned with the bruising and lacerations that he observed on Resident #101. HN E reported that he did not feel that any of the bruising appeared to be mottling or end of life progression. HN E' reported that he was concerned that the facility had not reported any kind of fall or reason that Resident #101 had the multiple bruises and lacerations. HN E reported that when he saw Resident #101 the following night, he also noted additional bruising on the top of her left foot, left knee, left hip and left check, and neck. HN E reported that the hospice aide had cared for Resident #101 on 10/28/24 and did not report any concerns or skin conditions. HN E reported that Resident #101's family had opted to have Resident #101 examined by a medical examiner due to the extent of her injuries that the facility could not provide a reason for how they were obtained. During an interview on 11/15/24 at 8:12 AM, DON B reported that she had been made aware of Resident #101's bruise on 10/28/24 and the new and additional bruising and lacerations on 10/29/24. DON B reported that she felt that Resident #101's injuries were related to her end stages of life. DON B confirmed that the facility did not contact the facility provider to assess Resident #101. DON B reported that she had completed an investigation on Resident #101's injuries, but she did not report the injuries of unknown origin to the State Agency because she did not feel that the injuries were related to abuse. During an interview on 11/15/24 at 10:48 AM, Nursing Home Administrator (NHA) A reported that she had been made aware of Resident #101's bruise on 10/28/24 and the new and additional bruising and lacerations on 10/29/24. NHA A reported that she did not report Resident #101's injuries of an unknown origin because she did not feel that the injuries were related to abuse. Review of the facility policy Abuse, Neglect, and Exploitation revealed the abuse policy did not define nor indicate what the facility should do regarding an injury of unknown orgin per the Code of Federal Regulations, State Operations Manual.