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	09/04/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to Intake # 2606671.Based on interview, and record review, the facility failed to protect the resident's right to be free from misappropriation of property in 1 of 4 residents (Resident #103) reviewed for misappropriation of property, resulting in the resident's money being taken by a staff member without the resident's consent.Findings include:Resident #103Review of an admission Record revealed Resident #103 was a female with pertinent diagnoses which included anxiety.Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 6/20/25, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact.Review of a facility investigation revealed (Resident #103) reported to Life Enrichment staff .she was missing a small zippered purse/pouch with about $10 worth (of) quarters in it and that a second change pouch was empty that had previously had about $10 worth of quarters in it as well. She reported to the staff that she had them both on Friday when she put away her bingo money, and that she noticed them missing Monday morning. She reports that they were in her night stand drawer side by side and the missing zippered purse was a black/blue colored pouch with a small flap and a logo on it .An investigation was immediately started with the review of camera footage .Camera footage was reviewed for the weekend, starting Friday afternoon after (Bingo). Saturday 8/9/25 at 3:18:55pm an agency staff is seen entering the resident's room and comes out at 3:20:47pm. It is noted that when she comes out it appears that she has something heavy and full in her right pocket of her scrub top. Camera footage follows her up the hall where she pulls out a dark colored pouch from her right pocket, unzips it, and appears to insert something small into it. She then goes back into the employee area and takes money out of a pouch and purchases a bag of chips at approximately 3:25 (PM) then starts to leave but comes back to the vending machine and purchases a Gatorade using the same pouch. When she turns around the pouch is clearer on the camera and is a dark blue/purple in color. The footage of the pouch/purse was shown to the resident and she confirms that it is her missing change purse . In an interview on 9/3/25 at 2:43 PM with Administrator A and Director of Nursing (DON) B, camera footage was reviewed to confirm the evidence summarized within the facility investigation. Administrator A and DON B reported while reviewing the camera footage during the investigation, they observed Agency Certified Nursing Assistant (CNA) T enter Resident #103's room on 8/9/25 at approximately 3:18 PM, then exit a few minutes later. Administrator A and DON B confirmed Resident #103 was not in her room at that time, and when Agency CNA T exited the room at approximately 3:20 PM, the front pocket of her scrub top appeared weighed down (as if something heavy was in the pocket). Administrator A and DON B reported Agency CNA T then proceeded to the service hallway and purchased some items from the vending machines. Administrator A and DON B were able to capture a still from the camera footage showing Agency CNA T holding a small, dark-colored bag in her hand. Administrator A and DON B reported Resident #103 was shown the still from the camera footage and identified the small, dark-colored bag as her missing change purse.In an interview on 9/4/25 at 11:57 AM, Resident #103 reported she had two small bags with quarters in her nightstand in her room. Resident #103 reported one was a blue stuffed bird with approximately ten dollars of quarters inside, and the other was a small, dark-colored purse with an additional ten dollars of quarters. Resident #103 reported she recalled adding some money to one of the small bags (the blue stuffed one) and stated On Saturday morning (8/9/25) it was so full .I remember thinking I'm going to have to remove some quarters . Resident #103 reported on Monday, 8/11/25, she realized the small, dark-colored purse was missing and the blue stuffed bird bag was empty. Resident #103 reported she notified staff, and they searched her room with no bag or quarters found. Resident #103 reported the facility completed an investigation into her missing bag/money and showed her a photo of Agency CNA T holding a small bag near the vending machines. Resident #103 identified the small purse in the photo as her missing coin purse, and stated, They showed me her hand, and she was holding the bag . Resident #103 stated, I felt really bad. I was hurt because this is my home .I want to feel safe here. I didn't want to accuse anyone . Resident #103 recalled her interactions with Agency CNA T and described her as standoffish. Resident #103 reported she did not recall Agency CNA T ever assisting her (Resident #103) with care and stated she (Resident #103) makes her own bed and there was no reason for Agency CNA T to be in her (Resident #103's) room on 8/9/25.In an interview on 9/4/25 at 1:19 PM, Director of Social Services C reported on 8/11/25 there was a staff meeting and a life enrichment staff member reported Resident #103 had some missing money. Director of Social Services C reported Administrator A and DON B were notified and an investigation was initiated

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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 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. (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 0689 Level of Harm - Actual harm Residents Affected - Few	This citation pertains to Intake # 2605454.Based on interview, and record review, the facility failed to implement care plan interventions to ensure safety and thoroughly document/investigate a fall in 1 of 4 residents (Resident #102) reviewed for safety and fall prevention, resulting in a fall with a right fibula fracture for Resident #102, and the potential for additional falls/injuries.Findings include:Resident #102Review of an admission Record revealed Resident #102 was a female, with pertinent diagnoses which included cerebral palsy (a congenital disorder of movement, muscle tone, or posture), Alzheimer's disease, dementia, depression, osteoporosis (a condition in which the bones become weak and brittle), and arthritis.Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 7/11/25, revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated moderate cognitive impairment.Review of a Care Guide for Resident #102, dated 8/11/25, revealed TOILETING .2 ASSIST WITH GAIT BELT TO STAND AT GRAB BAR IN BATHROOM WHILE COMMODE IS PLACED BEHIND HER .In an interview on 9/3/25 at 12:48 PM, Certified Nursing Assistant (CNA) F reported she responded to Resident #102's room on 8/17/25 at approximately 9:30 PM after CNA U called over the walkie for assistance. CNA F reported when she arrived at the room, she observed both Resident #102 and CNA U on the floor in the bathroom, with the CNA's right arm and right leg underneath the resident. CNA F reported she was told by CNA U that Resident #102 was lowered to the floor and did not hit her head. CNA F reported Resident #102 did not complain of pain at that time, and after Licensed Practical Nurse (LPN) K assessed Resident #102, she (CNA F) and LPN K used a gait belt to transfer Resident #102 up into her wheelchair, then into bed. CNA F reported a few hours later, Resident #102 put her call light on and complained of a cramp in her leg. CNA F stated, I rubbed it a little bit but that didn't help. CNA F reported she then notified the nurse of the new pain complaint. CNA F reported staff should always check the Care Guide before providing care to a resident. CNA F reported when an incident like this occurs, the nurse will typically complete an incident report. CNA F reported after the incident involving Resident #102 on 8/17/25, LPN K did not complete an incident report.In an interview on 9/3/25 at 1:15 PM, CNA U reported on 8/17/25 at approximately 9:30 PM she was assisting Resident #102 to the bathroom and stated .I did not realize she was a two-person (assist) . CNA U reported Resident #102 stood at the grab bar and she (CNA U) cleaned Resident #102 up and removed the commode from behind her. CNA U reported Resident #102 then stated, Oh no! and started to tilt sideways, losing her balance. CNA U reported she held up Resident #102's pants and lowered her to the floor, and stated, I was kind of underneath her. I slowly lowered her to the floor because I couldn't get to my walkie. I called once she was on the floor . CNA U reported after she called for assistance, CNA F and LPN K responded. CNA U reported LPN K assessed the resident and checked her vital signs. CNA U reported initially Resident #102 did not complain of pain, but once Resident #102 was transferred to bed she started complaining of a leg cramp. CNA U reported they did have a Fall Huddle in the room but reported she was unsure if an incident report was completed. CNA U reported she learned after the incident that Resident #102 was a two-staff assist in the bathroom, and that this change to her Care Guide had occurred a few days prior to the incident. CNA U reported the Care Guide should be checked before providing care to a resident and acknowledged that she did not check the Care Guide prior to assisting Resident #102 to the bathroom on 8/17/25.In an interview on 9/3/25 at 2:00 PM, CNA G reported on 8/18/25 she was assisting Resident #102 with morning care, and the resident complained of pain in her right leg. CNA G reported when Resident #102 was rolled onto her left side, her right leg hurt more. CNA G reported staff ended up using a dependent lift on 8/18/25 to transfer Resident #102 to her wheelchair due to the pain, which was unusual for Resident #102. CNA G stated, I could tell in her face that it hurt. CNA G reported Resident #102 was able to stand at the grab bar later in the afternoon on 8/18/25 and reported her right leg was still sore, but she was able to put pressure on it. CNA G reported Care Guides provide guidance on how to care for the residents and are posted in the closets. CNA G reported the Care Guide should always be checked before providing care to a resident.In an interview on 9/4/25 at 8:17 AM, CNA H reported on 8/19/25 Resident #102 complained of right leg pain when being assisted with bed mobility. CNA H reported she did not observe any visible injuries, and when asked Resident #102 could not recall a cause or reason for the pain in her right leg.In an interview on 9/4/25 at 11:18 AM, LPN K reported on 8/17/25 at approximately 9:30 PM, CNA U called via a walkie for assistance in Resident #102's room. LPN K reported when she arrived at Resident #102's room, she observed Resident #102 on the floor in the bathroom on her right side, with CNA