STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235020	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Michigan Masonic Home	1200 Wright Avenue Alma, MI 48801

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide dignified care to 3 residents (R5, R11, and R87) of 4 residents reviewed for dignity.Findings include: R5 Review of an admission Record revealed R5 admitted to the facility on [DATE] with pertinent diagnoses which included cerebral palsy and periodic limb movement disorder. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R5, with a reference date of 12/24/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R5 was cognitively intact. Further review of same MDS assessment revealed R5 was occasionally incontinent of urine. Review of the current toileting Care Plan intervention for R5, with a revision date of 1/26/2022, directed staff to toilet resident for bowel and bladder on request and offer a urinal every two hours around the clock. In an interview on 1/26/2026 at 1:36 PM, R5 reported he routinely waited for 30 minutes for his call light to be answered. R5 reported he took medication that caused him to urinate a lot, and the call light response was not always fast enough to prevent episodes of incontinence. Review of R5's call light report from 1/20/2026 to 1/27/2026 revealed the following.1/20/2026- call light activated at 8:29 AM with 28 minutes elapsed until answered1/22/2026- call light activated at 6:14 AM with 27 minutes elapsed until answered1/22/2026- call light activated at 7:47 PM with 31 minutes elapsed until answered1/24/2026- call light activated at 7:02 AM with 59 minutes elapsed until answered1/24/2026- call light activated at 10:08 AM with 24 minutes elapsed until answered1/24/2026- call light activated at 11:54 AM with 18 minutes elapsed until answered1/24/2026- call light activated at 6:37 PM with 27 minutes elapsed until answered1/25/2026- call light activated at 4:46 PM with 28 minutes elapsed until answered1/25/2026- call light activated at 6:33 PM with 36 minutes elapsed until answered1/25/2026- call light activated at 8:15 PM with 19 minutes elapsed until answered1/26/2026- call light activated at 1:44 AM with 20 minutes elapsed until answered1/26/2026- call light activated at 10:12 PM with 26 minutes elapsed until answered In an interview on 1/28/2026 at 10:21 AM, R5 reported the previous Saturday, 1/24/2026, he waited an extended period in bed after pressing his call light (59 minutes per call light report) that morning (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and was unable to hold his urine and wet himself. R5 reported this made him feel undignified. R11 Review of an admission Record revealed R11 admitted to the facility on [DATE] with pertinent diagnoses which included Parkinson's Disease and unsteadiness on feet. Review of a current toileting Care Plan intervention for R11, with a revision date of 9/9/2025, directed staff to toilet resident every 2 hours while awake and upon request. In an interview on 1/26/2026 at 2:55 PM, R11 reported he often waited 30 minutes for his call light to be answered and often urinated on himself because he could not hold his urine that long. R11 reported this made him feel like he was not wanted. Review of R11's call light report from 1/20/2026 to 1/27/2026 revealed the following.1/20/2026- call light activated at 9:43 AM with 32 minutes elapsed until answered1/21/2026- call light activated at 8:24 AM with 18 minutes elapsed until answered1/21/2026- call light activated at 11:20 AM with 22 minutes elapsed until answered1/21/2026- call light activated at 2:01 PM with 27 minutes elapsed until answered1/21/2026- call light activated at 2:43 PM with 28 minutes elapsed until answered1/22/2026- call light activated at 6:32 AM with 31 minutes elapsed until answered1/22/2026- call light activated at 3:09 PM with 17 minutes elapsed until answered1/22/2026- call light activated at 6:43 PM with 19 minutes elapsed until answered1/22/2026- call light activated at 7:28 PM with 25 minutes elapsed until answered1/23/2026- call light activated at 12:50 AM with 22 minutes elapsed until answered1/23/2026- call light activated at 5:46 AM with 28 minutes elapsed until answered1/23/2026- call light activated at 7:06 AM with 29 minutes elapsed until answered1/23/2026- call light activated at 9:13 AM with 34 minutes elapsed until answered1/23/2026- call light activated at 4:21 PM with 28 minutes elapsed until answered1/23/2026- call light activated at 9:02 PM with 24 minutes elapsed until answered1/24/2026- call light activated at 5:11 AM with 18 minutes elapsed until answered1/24/2026- call light activated at 10:04 AM with 23 minutes elapsed until answered1/24/2026- call light activated at 5:20 PM with 30 minutes elapsed until answered1/24/2026- call light activated at 6:34 PM with 25 minutes elapsed until answered1/24/2026- call light activated at 9:38 PM with 21 minutes elapsed until answered1/25/2026- call light activated at 1:36 AM with 24 minutes elapsed until answered1/25/2026- call light activated at 6:48 AM with 37 minutes elapsed until answered1/25/2026- call light activated at 9:38 AM with 27 minutes elapsed until answered1/25/2026- call light activated at 9:43 PM with 61 minutes elapsed until answered1/26/2026- call light activated at 1:45 AM with 39 minutes elapsed until answered1/26/2026- call light activated at 10:15 AM with 32 minutes elapsed until answered1/26/2026- call light activated at 7:06 PM with 23 minutes elapsed until answered1/26/2026- call light activated at 11:12 PM with 26 minutes elapsed until answered R87 Review of the Electronic Medical Record (EMR) admission Record reflected R87 admitted to the facility 8/5/24 with pertinent diagnoses that included diagnoses that included Orthostatic Hypotension (a measurable drop in blood pressure when standing from lying or sitting that may result in lightheadedness), Syncope (fainting), and Collapse. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Minimum Data Set (MDS) (a resident assessment tool) dated 11/5/25 reflected a Brief Interview for Mental Status (BIMS) (a scale used to assist to determine a resident's cognitive status) reflected R87 had a score of 15 out of 15 which indicated the Resident was cognitively intact. On 1/26/26 an interview was conducted with R87 in her room. R87 reported she fell about 6 months prior because she self-transferred to use the bathroom when staff did not respond timely to her call light. R87 reported she has a walker, but staff have told her to wait for assistance because she might fall and break her hip. R87 stated that scares me. R87 reported since then there have been instances of slow call light response when she wanted to use the bathroom that resulted in either soiling or wetting herself. R87 reported this makes her feel helpless and had asked staff, how it would make them feel if they had to sit in their own poop and pee. R87 reported once she soiled herself when started on bowel medication. The Resident indicated she is proud and has visitors but doesn't want people coming to see her when the room smells like poop. R87 reported it really bothers her when she voids on herself. Review of the call light report for R87 from 1/20/26 to 1/25/26 revealed: 1/20/26 call light activated at 8:44 AM with 26 minutes elapsed until suspended. 1/21/26 call light activated at 2:19 AM with 29 minutes elapsed until suspended. 1/22/26 call light activated at 1:00 PM with 22 minutes elapsed until suspended. 1/23/26 call light activated at 8:03 AM with 37 minutes elapsed until suspended. 1/23/26 call light activated at 9:55 AM with 36 minutes elapsed until suspended. 1/23/26 call light activated at 11:20 AM with 28 minutes elapsed until suspended. 1/24/26 call light activated at 6:46 PM with 31 minutes elapsed until suspended. 1/24/26 call light activated at 8:40 PM with 36 minutes elapsed until suspended. 1/25/26 call light activated at 9:53 AM with 29 minutes elapsed until suspended. 1/25/26 call light activated at 8:11 PM with 32 minutes elapsed until suspended. During a second interview conducted 1/28/26 at 9:22 AM R87 reported instances when staff had turned off the call light and returned later to provide the aid needed. R87 added, They are real busy. R87 reported at these times she had not re-initiated the call light but that sometimes she was unable to hold her urine until staff returned.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a pressure relieving care plan for 1 Resident (R28) of 1 Resident reviewed for care plans.Findings included:R28Review of R28's admission record dated 1/28/26 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: chronic pain, dysuria (frequent urination), reduced mobility, and chronic kidney disease. R28 was her own responsible party.Review of R28's Brief Interview of Mental Status (BIMS), a mental/cognitive assessment, dated 12/2/25 revealed R28 scored 15 out of 15 (normal mental status).Review of R28's skin integrity care plan revision date of 11/06/25 revealed, I have actual impairment to skin integrity r/t (related to) hemiplegia/hemiparesis (paralysis of half of the body). Interventions included: cushion for chair dated 10/25/25. No interventions were noted for the toilet or bedpan.On 1/27/26 at 1:26 PM, R28 was observed sitting in her room in her wheelchair. R28 complained of buttock pain, pain when she sits on the toilet and bed pan for extended periods of time. Certified Nursing Assistant (CNA) H came in the room to assist R28 and R28 was agreeable to allowing the Surveyor to check the skin on her buttock. CNA H assisted R28 to stand and remove R28's pants. R28 pointed to her coccyx area when explaining where she hurt. The coccyx and sacral area were coated with a thick white substance. Some skin was observed to be darker in the sacral area than the rest of her buttock. The coccyx was not visible. R28 was sitting on a green pad. CNA H said R28 was to be sitting on a pressure relief cushion. CNA H could not locate the cushion that was normally in R28's wheelchair. CNA H obtained a different seat cushion. R28 took the disposable cover off her drink and ran her finger around the edge and said the outside of the cup was like the bed pan and explained the edge hurt her buttock when she sat on it.During an observation and interview with R28 on 1/29/26 at 10:37 AM, R28 was sitting on the toilet in her bathroom. R28's feet were several inches off the floor and R28 was complaining of the toilet seat hurting her buttock. R28's Charge Nurse, CN M was asked to come evaluate R28's buttock pain and need for assistance. CN M asked R28 if she could shift her weight off where it hurt. R28 tried but said she could not. CN M handed R28 the bed pan she uses and asked where the bedpan hurt her and R28 pointed to the narrow sides with her fingers.

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F 0689 Level of Harm - Minimal harm or potential for 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 falls for 2 residents (R11 and R38) of 5 residents reviewed for falls.Findings include:R11 Review of an admission Record revealed R11 admitted to the facility on [DATE] with pertinent diagnoses which included Parkinson's Disease and unsteadiness on feet. Review of a current toileting Care Plan intervention for R11, with a revision date of 9/9/2025, directed staff to toilet resident every 2 hours while awake and upon request. In an interview on 1/26/2026 at 2:55 PM, R11 reported he often waited 30 minutes for his call light to be answered. R11 reported he was unable to hold his urine that long and often urinated on himself while waiting for assistance. Review of R11's Note Text in the Electronic Medical Record (EMR), dated 1/13/2026 at 2:04 PM revealed .This writer was called into resident's room by CNA, who stated that resident was noted to be sitting on the floor of his bathroom. Resident stated that he needed to use the bathroom and could not wait so he tried getting on the toilet but was unable to make it onto the toilet, and he had to sit down on the floor. Review of R11's Note Text in the EMR, dated 1/27/26 at 2:38 PM, revealed .IDT (Inter-Disciplinary Team) post fall huddle and Root-Cause Analysis performed. On 1/13/26 at 1250 (R11) was observed to be seated on the floor of his bathroom. He reported to the staff that he was trying to get on the toilet but was unable to make it onto the toilet and he sat down on the floor. He had urinated on the bathroom floor. He had his call light on prior to self-transferring, but (R11) is not patient and. tries to transfer without being strong enough to complete the transfer safely. Root causes of irritability and impulsiveness were discussed by IDT. Further review of the report revealed it did not state how long R11's call light had been activated prior to staff finding him on the bathroom floor and it did not identify the length of the call light wait time as part of the root cause of this fall. In an interview on 1/28/2025 at 3:47 PM, the Nursing Home Administrator (NHA) reported she would provide the call light report for R11 on 1/13/2025. The NHA did not know why this information was not reviewed in the post fall huddle Root-Cause Analysis. Review of R11's Past Calls report, dated 1/13/2026, revealed his bathroom pull station call light was activated at 12:25 PM with 28 minutes elapsed until staff turned the call light off at 12:53 PM. In an interview on 1/29/2026 at 10:22 AM, Registered Nurse (RN) Charge Nurse M discussed the 28-minute wait time in between when R11 activated the bathroom call light at 12:25 PM and the staff response at 12:50 PM. RN Charge Nurse M reported 28 minutes was longer than a resident should be required to wait for assistance using the bathroom. In an interview on 1/29/2026 at 10:42 AM, the NHA did not have a reason that the call light wait time was not included in the post fall Huddle and Root Cause Analysis performed for this fall. Review of the facility policy/procedure Incidents & Accidents Policy, revised 11/2023, revealed .The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting a root cause analysis to ascertain causative/contributing factors as part of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. R38 Review of an admission Record revealed R38 admitted to the facility on [DATE] with pertinent diagnoses which included Parkinson's disease, dementia, psychotic disorder with hallucinations, delusional disorder, and major depressive disorder. In an observation on 01/29/2026 at 8:19 AM, R38 ambulated into the hallway from his room utilizing a two-wheeled walker. R38 walked down the opposite hallway from his room (closed rooms) and observed a lighted sign on the wall. R38 was without staff presence at the end of this hallway. R38 attempted to enter another resident room in the hallway as he ambulated toward the nurse's station. Staff members walked through the hallway past R38 and did not attempt to approach. R38 then ambulated to the common area where the television played an Elvis video. R38 stepped backward multiple steps tipping his front walker legs off from the floor. Staff noted to be in another hall and in other resident rooms. One staff member was observed with a breakfast hall tray that she returned to the kitchen; another staff member was observed in the dirty linen room. R38 ambulated back to the end of the same hallway (closed rooms) and proceeded to turn around when he reached the end of the hallway. R38 ambulated without his walker back from the hallway to lean against the nurse's station. There were no staff present at the nursing station or within sight. Review of a current activities of daily living Care Plan intervention for R38, initiated 04/17/2025, directed staff that R38 required supervision with a two-wheeled walker for ambulation. In an interview on 01/29/2026 at 8:49 AM, Licensed Practical Nurse (LPN) K was queried what supervision with ambulation would mean in the care plan. LPN K replied that supervision with ambulation means that staff keep visual eyeline at all times with the resident. LPN K observed during response that R38 was standing at the nursing station without his walker. LPN K assisted R38 to obtain his walker and redirected him to his room. In an interview on 01/29/2026 at 8:59 AM, Certified Nursing Assistant (CNA) E was queried what supervision with ambulation would mean in the care plan. CNA E stated it meant staff were supposed to keep R38 visually in sight. In an interview on 1/29/26 at 9:06 AM, CNA F was queried what supervision with ambulation would mean in the care plan. CNA F stated you have to watch them when they walk. When asked which residents on the unit required supervision with ambulation CNA F was unable to identify which residents required supervision with ambulation. In an interview on 1/29/26 at 9:13 AM, Registered Nurse (RN) Charge Nurse N was queried what supervision with ambulation would mean in the care plan. RN Charge Nurse N stated you would be with that resident; you are supervising them. RN Charge Nurse N reported that supervision is when staff always has that resident in their line of sight.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently provide clear and concise medical records for 2 residents (R9 and R12) of 20 residents reviewed.R9Review of a resident admission Record revealed R9 admitted to the facility on [DATE] with pertinent diagnoses which included parkinsonism, bipolar disorder, anxiety disorder, and heart failure. Review of R9's electronic medical records (EMR) revealed (Facility Name) Interdisciplinary Conference Report Sheets dated 02/11/25, 5/13/25, and 8/12/25 were marked as the Quarterly option with an X. Further review revealed Resident in attendance: Yes or No all sheets presented with a check mark beside No. Resident family/legal representative in attendance? Yes or No the sheets presented with a check mark beside No. Further review revealed check mark stating completion of a baseline care plan summary encompassing updates to goals, medications, dietary information, and treatments since the last care plan summary had been completed with Resident and/or Resident family/legal representative although Resident and Resident family/legal representative were both marked as not in attendance. Review of R9's EMR revealed (Facility Name) Interdisciplinary Conference Report Sheet dated 10/21/25, with the Quarterly option check marked. Further review revealed Resident in attendance: Yes or No presented a check mark beside No. Resident family/legal representative in attendance? Yes or no presented blank. Further review revealed check mark stating completion of a baseline care plan summary encompassing updates to goals, medications, dietary information, and treatments since the last care plan summary had been completed with Resident and/or Resident family/legal representative although Resident and Resident family/legal representative were both marked as not in attendance. R12Review of a resident admission Record revealed R12 admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease and major depressive disorder.Review of R12's EMR revealed (Facility Name) Interdisciplinary Conference Report Sheet dated 10/16/25, with the Quarterly option checked yes. Further review revealed Resident in attendance: Yes: or No: presented blank. Resident family/legal representative in attendance? Yes: or No: presented blank. Further review revealed check mark stating completion of a baseline care plan summary encompassing updates to goals, medications, dietary information, and treatments since the last care plan summary had been completed with Resident and/or Resident family/legal representative although Resident and Resident family/legal representative were both marked as not in attendance. Review of R12's electronic medical record on 01/27/2026 revealed (Facility Name) Interdisciplinary Conference Report Sheet dated 01/13/2026, with Annual option checked yes. Report Sheet requested Resident in attendance: Yes: or No: presented a check mark beside No. Resident family/legal representative in attendance? Yes: or No: presented blank. Further review revealed check mark stating completion of a baseline care plan summary encompassing updates to goals, medications, dietary information, and treatments since the last care plan summary had been completed with Resident and/or Resident family/legal representative although Resident and Resident family/legal representative were both marked as not in attendance. In an interview and record review on 01/28/2026 at 9:00 AM the Social Service Designee (SSD) R reported that care conferences were completed on paper and when the care conference was completed the paper was taken to be signed by the resident's physician and after the physician signed the care conference was uploaded into the resident's chart. SSD R reported the care conference paperwork should be filled out in its entirety to assist with family involvement.In an interview on 01/28/2026 at 1:00 PM, questioned the Registered Nurse (RN) Charge Nurse N if the expectation would be to have resident/representative involvement for the section that states Baseline Care Plan summary completed with resident/representative including to updates to goals, medications, and dietary information, services, and treatments since initial baseline care plan, RN Charge Nurse N responded yes. Review of facility policy/procedure (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Documentation Policy, updated 03/2023, revealed .each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the potential for increased risk of respiratory infection among all residents in the facility. Findings include: On 01/27 at 9:13AM, a drinking fountain was observed that appears to be used inconsistently, located in the unused Boardroom wing on the Ground Level. The basin of the drinking fountain was dry at time of observation. Director of Environmental Services (DES) U was asked about use of the drinking fountain and the flushing schedule for the fountain at that time. DES U indicated they were unsure about the flushing schedule or use of the drinking fountain due to the area being used mainly for storage and that sometimes the restroom facilities are used by facility personnel. Record review of the facility's policy, Michigan Masonic Home, Water Management Program Policy MN-D 153 Procedure 2, states A risk assessment will be conducted by the water management team annually., indicating the drinking fountain would have been assessed annually and status of flushing schedule known.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to monitor lab results and promote communication between health care providers to maintain an effective antibiotic stewardship program to ensure timely identification and treatment of an infection for one Resident (R103) of six residents reviewed for medications. Findings include:Review of the Electronic Medical Record (EMR) reflected R103 admitted to the facility 8/18/16 with pertinent diagnoses that included a history of urinary tract infections (UTI).Review of the EMR Progress Note entry on 1/2/26 at 4:31 PM reflected a urinalysis was ordered by a physician.Review of the EMR Progress Note entry on 1/4/26 at 2:49 PM reflected the urine specimen had been obtained and sent to the laboratory for analysis.Review of the EMR revealed abnormal urine lab results on 1/4/26 and that a culture and sensitivity (C and S) was to be completed. The document included a physician note dated 1/7/26 at 9:31 AM, UA positive for kleb penumoniae (sic) (a bacterial urinary tract infection), will start 7-day course of Ceftin (antibiotic). Extended course due to hematuria (blood in urine) as well. Called (name of facility) to update result.Review of the EMR revealed documentation of Culture and Sensitivity results Last Resulted 1/6/26 at 7:47 AM. The result reflected the culture result of >100000 col/ml Klebsiella Pneumoniae. The document included the same note from the physician that (name of facility) had been contacted and that the 7-day course of an antibiotic would be started.Review of the EMR did not reflect documentation of the positive lab result for UTI or the need for an antibiotic until 1/16/26 at 15:28 when an antibiotic was ordered.) No documentation was found in the EMR of monitoring for the results of the urine specimen submitted by facility 1/4/26.Review of the January 2026 Medication Admisnistration Record (MAR) for R103 reflected antibiotic therapy was initiated the evening of 1/16/26.On 1/28/26 at 11:38 AM, an interview was conducted with Infection Preventionist (IP) G. IP G reported that the charge nurses will inform her of residents with suspected infections, if a urine sample was sent to the lab, or if a physician wanted to start an antibiotic. The IP reported that she would follow up to make sure a note was entered into the medical record. IP G reported that the Medical Director follows most of the facility residents but that another Physician at the facility was responsible for a small number of residents. IP G reported that this Physician was following R103. The IP reported that the documentation of the lab results and the order for an antibiotic were placed in a separate hospital EMR and not the facility EMR. The IP indicated there was a miscommunication despite documentation in the facility EMR that a urine sample had been sent to the lab and was without monitoring for the results. The policy provided by the facility titled Infection Surveillance Policy last revised 9/2025 was reviewed. The policy reflected It is the policy of (name of facility) to have a system of infection surveillance services as a core activity of the (facility's) infection prevention and control program's purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices . And Procedure: .2. The nurses participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in-house reporting of communicable disease and infections. Examples of notification triggers include, but not limited to: a. Resident develops signs and symptoms of infection.c. A microbiology test is ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235020	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Michigan Masonic Home	1200 Wright Avenue Alma, MI 48801

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain general cleanliness and repair of the premises. Findings include: On 01/27/2026 at 8:30AM, a patch of black mold-like substance was observed, 2 feet long by 1 foot wide, at eye level, on the wall in the Water room, located in Maintenance and Laundry wing of Ground Level. Director of Facilities (DF) T confirmed the observation at the time of walk through. There was no visible explanation at time of observation, as the wall was dry and there were no notable high humidity issues in the room.