STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235054	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Manor Senior Care Center	111 Evergreen Battle Creek, MI 49015

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 3/31/26 at 10:02 AM, observation of the mop sink closet in the kitchen found that a hot water storage tank was placed where the old mop sink was located. At this time, it was observed that the hot water line from the old mop sink was connected to the storage tank and the cold-water line was observed connected to nothing, indicating a stagnant water line. On 3/31/26 at 10:49 AM, observation of the 300 hall Soiled Utility room found that the hopper fixture had been removed from the room. When asked if the water lines that were left, from the hopper being removed, were on a flushing schedule, Plant Operations Director (POD) P stated that the facilities flushing schedule is every Friday for eye wash stations and some minimal use fixtures, but the lines for the removed hoppers are not flushed. When asked if their water lines ran through the cement floor or through the ceiling, POD P stated that they ran through the ceiling. On 3/31/26 at 10:55 AM, observation of the housekeeping closet, between the 300 and 400 halls, found that the cold-water valve had been taken off the mop sink. When asked why, POD P stated that the housekeeping chemicals are only used with hot water. When asked if the cold side ever gets flushed on Fridays, POD P stated it was not something they currently did. On 3/31/26 at 11:27 AM, observation of the 400 hall Soiled Utility room found the hopper was removed and the water lines were left intact (same set up as the 300 Soiled Utility room). On 3/31/26 at 11:43 AM, observation of the housekeeping closet between the 100 and 200 halls, found that the cold valve was removed from the mop sink faucet, indicating minimal use and a stagnant water line. On 3/31/26 at 11:52 AM, observation of the 100 hall Soiled Utility room found a removed hopper with water lines still present. POD P stated that he would get their plumber out and remove all the stagnant unused lines to within six inches of the main line (so they are no longer creating areas of domestic water stagnation). On 3/31/26 at 12:02 PM, observation of the shared bathroom at the end of the 100 hall, between the end of the hall storage room and the conference room, found that the commode and sink had been removed from this area and the water fixtures were left intact. When asked how long ago this area has been without a sink and commode intact, POD P stated it has been that way since covid (2020). When asked if this was on a flushing schedule, POD P stated that he will make sure it gets addressed. On 3/31/26 at 2:20 PM, a discussion of the facilities WMP plan occurred with POD P and Assistant POD Q. When asked about testing for free chlorine, POD P stated that they use a test strip monthly and that their results are typically 0.5 or 1.0 parts per million (ppm).Observation of the facility provided test strips found that Total Chlorine was underlined, and the range was in half (0.5) ppm increments via a color variant. The test strips left no viable way to discern between levels of free chlorine that were in between 0 ppm and 0.5 ppm, or 0.5 ppm to 1.0 ppm, leaving the POD P to pick the closest resembling color for a concentration.A record review of the facility provided document entitled Water Management Plan, dated July 1, 2025, found that a listed control measure for the facility is Disinfectant (Free Chlorine) Level Checks. Under the Task 1 heading it states that, Use a free and total chlorine test kit that can accurately read to 0.1 ppm.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review the facility failed to ensure that one resident (#100) was treated with dignity and care in manner that promotes maintenance or enhancement of her quality of life out of one resident reviewed for dignity.Findings included: Resident #100 (R100)Review of the medical record revealed R100 was admitted [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction caused by chemical imbalance, urinary tract infection, hypertension, difficulty walking, and muscle weakness. Review of R98's document entitled Brief Interview of Mental Status (3.0 BIMS), completed 03/30/2026, revealed a BIMS score of 15 (cognitively intact) out of 15.On 03/31/2026 at 09:31 a.m. during observation and interview R100 was observed lying down in bed. R100's daughter V was observed sitting in a chair at her bedside. R100 explained that she had a concern regarding her care. She explained that sometime in the middle of the night an aide had told her just to urinate in her brief because the aide did not have time to take her to the bathroom. R100 explained that she urinated in her brief. R100 explained that the aide came back later and provided continent care to her.During the same interaction above R100's daughter V explained that R100 had told her about an incident that occurred Sunday evening around 04:00 a.m. R100's daughter V explained that her mother explained that she had placed her call light on, because she needed to go to the bathroom. R100's daughter V explained that her mother told her that an aide had told her to go in her brief because she did not have time to take her to the bathroom. R100's daughter V explained that her mother told her that she urinated in her brief. R100's daughter V explained that her mother was being treated for a Urinary infection and could not hold her urine. R100's daughter V explained that her mother had not been treated with dignity and respect. R100's daughter explained that she had explained this to the Nursing Home Administrator and was just told that the aide that was involved was new and that the issue had been addressed with the employee.On 04/01/2026 at 09:03 a.m. Director of Nursing (DON) B explained that it was her expectation that residents would be provided urinary care based upon their needs and their plan of care. DON B was asked if she had any knowledge of R100 being told to urinate in her brief because the aide did not have time to take her to the bathroom? DON B explained that she did not have knowledge of the incident and explained that it would not be acceptable for staff to inform a resident to urinate in a brief. DON B explained that staff should have taken her to the bathroom, provided her a bed pan, or provided a bedside commode.

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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 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** Based on observation, interview, and record review the facility failed to report an allegation of neglect/abuse to the appropriate state survey agency for one resident (#100) of one resident reviewed for neglect/abuse.Findings Included:Resident #100 (R100)Review of the medical record revealed R100 was admitted [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction caused by chemical imbalance, urinary tract infection, hypertension, difficulty walking, and muscle weakness. Review of R98's document entitled Brief Interview of Mental Status (3.0 BIMS), completed 03/30/2026, revealed a BIMS score of 15 (cognitively intact) out of 15.On 03/31/2026 at 09:31 a.m. during observation and interview R100 was observed lying down in bed. R100's daughter V was observed sitting in a chair at her bedside. R100 explained that she had a concern regarding her care. She explained that sometime in the middle of the night an aide had told her just to urinate in her brief because the aide did not have time to take her to the bathroom. R100 explained that she urinated in her brief. R100 explained that the aide came back later and provided continent care to her.During the same interaction above R100's daughter V explained that R100 had told her about an incident that occurred Sunday evening around 04:00 a.m. R100's daughter V explained that her mother explained that she had placed her call light on, because she needed to go to the bathroom. R100's daughter V explained that her mother told her that an aide had told her to go in her brief because she did not have time to take her to the bathroom. R100's daughter V explained that her mother told her that she urinated in her brief. R100's daughter V explained that her mother was being treated for a Urinary infection and could not hold her urine. R100's daughter V explained that her mother had not been treated with dignity and respect. R100's daughter explained that she had explained this to the Nursing Home Administrator and was just told that the aide that was involved was new and that the issue had been addressed with the employee.Review of the facility concern logs did not reveal any concern for R100.On 04/01/2026 at 08:31 a.m. the Nursing Home Administrator (NHA) A explained that he had been the facility Nursing Home Administrator for approximately a week and a half. NHA A explained that he was the facility abuse coordinator. NHA A explained the definitions of abuse and neglect. NHA A was asked if he had knowledge that R100 had reported that she was told to urinate in her brief because an aide did not have time to take her to the bathroom. NHA A explained that he was aware of the allegation and had investigated it and could not substantiate that it occurred. NHA A was asked if he any documentation that he could demonstrate that the incident was investigated. NHA A responded that he could put something together. NHA A was asked if he currently had any documentation demonstrating that the incident was investigated. NHA A responded that he did not currently have any documents. NHA A was asked if he had reported the allegation to the appropriate state agency. NHA A explained that since he could not substantiate the allegation, he did not report the incident. On 04/01/2026 at 09:03 a.m. Director of Nursing (DON) B explained that it was her expectation that residents would be provided urinary care based upon their needs and their plan of care. DON B was asked if she had any knowledge of R100 being told to urinate in her brief because the aide did not have time to take her to the bathroom? DON B explained that she did not have knowledge of the incident and explained that it would not be acceptable for staff to inform a resident to urinate in a brief. DON B explained that staff should have taken her to the bathroom, provided her a bed pan, or provided a bedside commode. DON B explained that this would have been an allegation of potential abuser or neglect and she would have reported this to the Nursing Home Administrator (NHA).On 04/01/2026 at 09:12 a.m. a telephone interview was conducted with Licensed Practical Nurse (LPN) BB. LPN BB explained that R100's daughter V had voiced a concern to her on Monday morning. LPN BB explained that R100's daughter V had told her that a CNA (Certified Nurse Aide) had told her mother to urinate in her brief or bed because they were short staffed and the CNA did not have time to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take her to the bathroom. LPN BB explained that she immediately had report the incident to NHA A because this was an allegation of abuse or neglect.On 04/01/2026 at 2:03 p.m. Nursing Home Administrator (NHA) A explained that he had reported the above allegation to the appropriate state agency today and provided a MIFRI number of 00064131. NHA A also explained that he was starting an investigation into the incident. Review of facility policy NEX-156K entitled Abuse, Neglect, and/or Misappropriation of Resident Funds or Property, origination date of 05/13/14 and revision date of 03/15/23, revealed e). Investigation i) Time Frame for Investigation (1) The investigation shell be initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days. The same policy revealed f) Reporting /Response i) for the alleged violation involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Center will report immediately but not later that than two hours after the allegation is made, if the events cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the state survey agency, local authorities as appropriate, adult protective services where stat law provide for jurisdiction in long term care facilities), in accordance with state law, and within 5 working days of the incident with the conclusion.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to adequately investigate an allegation of neglect/abuse for one resident (#100) of one resident review of neglect/abuse.Findings Included: Resident #100 (R100)Review of the medical record revealed R100 was admitted [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction caused by chemical imbalance, urinary tract infection, hypertension, difficulty walking, and muscle weakness. Review of R98's document entitled Brief Interview of Mental Status (3.0 BIMS), completed 03/30/2026, revealed a BIMS score of 15 (cognitively intact) out of 15.On 03/31/2026 at 09:31 a.m. during observation and interview R100 was observed lying down in bed. R100's daughter V was observed sitting in a chair at her bedside. R100 explained that she had a concern regarding her care. She explained that sometime in the middle of the night an aide had told her just to urinate in her brief because the aide did not have time to take her to the bathroom. R100 explained that she urinated in her brief. R100 explained that the aide came back later and provided continent care to her.During the same interaction above R100's daughter V explained that R100 had told her about an incident that occurred Sunday evening around 04:00 a.m. R100's daughter V explained that her mother explained that she had placed her call light on, because she needed to go to the bathroom. R100's daughter V explained that her mother told her that an aide had told her to go in her brief because she did not have time to take her to the bathroom. R100's daughter V explained that her mother told her that she urinated in her brief. R100's daughter V explained that her mother was being treated for a Urinary infection and could not hold her urine. R100's daughter V explained that felt her mother had not been treated with dignity and respect. R100's daughter explained that she had explained this to the Nursing Home Administrator and was just told that the aide that was involved was new and that the issue had been addressed with the employee.Review of the facility concern logs did not reveal any concern for R100.On 04/01/2026 at 08:31 a.m. the Nursing Home Administrator (NHA) A explained that he had been the facility Nursing Home Administrator for approximately a week and a half. NHA A explained that he was the facility abuse coordinator. NHA A explained the definitions of abuse and neglect. NHA A was asked if he had knowledge that R100 had reported that she was told to urinate in her brief because an aide did not have time to take her to the bathroom. NHA A explained that he was aware of the allegation and had investigated it and could not substantiate that it occurred. NHA A was asked if he any documentation that he could demonstrate that the incident was investigated. NHA A responded that he could put something together. NHA A was asked if he currently had any documentation demonstrating that the incident was investigated. NHA A responded that he did not currently have any documents. NHA A was asked if he had reported the allegation to the appropriate state agency. NHA A explained that since he could not substantiate the allegation, he did not report the incident. On 04/01/2026 at 09:03 a.m. Director of Nursing (DON) B explained that it was her expectation that residents would be provided urinary care based upon their needs and their plan of care. DON B was asked if she had any knowledge of R100 being told to urinate in her brief because the aide did not have time to take her to the bathroom? DON B explained that she did not have knowledge of the incident and explained that it would not be acceptable for staff to inform a resident to urinate in a brief. DON B explained that staff should have taken her to the bathroom, provided her a bed pan, or provided a bedside commode. DON B explained that this would have been an allegation of potential abuser or neglect and she would have reported this to the Nursing Home Administrator (NHA).On 04/01/2026 at 09:12 a.m. a telephone interview was conducted with Licensed Practical Nurse (LPN) BB. LPN BB explained that R100's daughter V had voiced a concern to her on Monday morning. LPN BB explained that R100's daughter V had told her that a CNA (Certified Nurse Aide) had told her mother to urinate in her brief or bed because they were short staffed and the CNA did not have time to take her to the bathroom. LPN BB explained that she immediately had report the incident to NHA A because this was an allegation of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse or neglect.On 04/01/2026 at 2:03 p.m. Nursing Home Administrator (NHA) A explained that he had reported the above allegation to the appropriate state agency today and provided a MIFRI number of 00064131. NHA A also explained that he was starting an investigation into the incident. Review of facility policy NEX-156K entitled Abuse, Neglect, and/or Misappropriation of Resident Funds or Property, origination date of 05/13/14 and revision date of 03/15/23, revealed e). Investigation i) Time Frame for Investigation (1) The investigation shell be initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days. The same policy revealed f) Reporting /Response i) for the alleged violation involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Center will report immediately but not later that than two hours after the allegation is made, if the events cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the state survey agency, local authorities as appropriate, adult protective services where stat law provide for jurisdiction in long term care facilities), in accordance with state law, and within 5 working days of the incident with the conclusion.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a written summary of the baseline care plan to one resident (#98) or residents representative out of 18 residents reviewed for baseline care plan.Findings included: Resident #98 (R98)Review of the medical record revealed R98 was admitted [DATE] with diagnoses that include stroke, atrial fibrillation, hyperlipidemia (high fat content in blood), respiratory failure, type 2 diabetes, aphasia (language disorder), right sided paralysis (loss of muscle function), dysphagia (difficulty swallowing), and insomnia. Review of R98's document entitled Brief Interview of Mental Status (3.0 BIMS), completed 03/31/2026, revealed a BIMS score that was not assessed related to R98's medical condition. On 03/31/2026 at 09:06 a.m. R98 was observed lying down in bed. R98 did not respond to verbal questions.Review of R98's medical record revealed an interim plan of care that was initiated upon admission. During an interview on 03/31/2026 at 03:08 p.m. R98's daughter R was asked if she or her father (R98) had received a copy of R98's base line plan of care. R98's daughter explained that she had not nor her father (R98) had received a copy of R98's base line plan of care.On 03/31/2026 at 03:09 p.m. Director of Nursing (DON) B explained that it was her expectation that each Resident or Residents representative would receive a copy of their baseline plan of care. DON B explained that it was her expectation that the copy of a Residents baseline plan of care would be provided in within 48 hours. DON B explained that documentation would be included in the base line plan of care that demonstrated that the Resident or the Residents representative would have been given a copy of the baseline plan of care. DON B was asked to review R98's base line care plan. DON B confirmed that documentation was not present in R98's plan of care that demonstrated that he or his representative had received a copy of his base line plan of care.