STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235058	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lapeer County Medical Care Facility	1455 Suncrest Drive Lapeer, MI 48446

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 - 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** This Citation Pertains to Intake Number 2661843. Based on observation, interview and record review, the facility failed to ensure supervision was provided during mealtime for two residents (#1 and 2), who had safe swallow instructions during meals, of four Residents reviewed for dining and assistance with meals. Findings include:On 11/13/25 at 12:15 PM, an observation was made of the dining room on the second floor during the lunchtime meal. The following observations were made:-Resident 1 (R1) was sitting in a Broda chair. The Broda chair is slightly reclined. There were two men working on the construction near the cabinets with yellow caution tape blocking the area. Resident 1 is positioned facing the construction area. -Resident 2 (R2) was positioned at a table with two other residents with her back towards the construction area and facing the outer wall. -At 12:32 PM, lunch trays are passed on the 2nd floor dining area. The hot food is served onto plates on the other side of the kitchenette area and not in vision of the Residents on the other side of the kitchenette/counter area. Staff come around from the other side where the hot food was located and delivered Residents' food. They set the Resident's food down on the table and then left the area to get another Resident their food. Most Residents had their food.-Resident 1 is seated in her Broda chair, reclined slightly, has shirt protector on and eating her food. Staff have left the dining area-At 12:33 PM, Resident 2 was given her meal and staff left the Resident with out directive or encouragement to eat. Resident 2 did not have a shirt protector on. All food items on ticket were received. R2 picked up a fork and pushed the cooked broccoli around on her plate. Meat was received cut into bite size pieces. The Resident did not eat any food but had taken some sips of V8 juice. Staff left the area after the food was given to R2.-At 12:48 PM, an observation was made of staff not in the dining area consistently while Residents are eating. R1 was eating without being monitored for safety. R2 has not eaten a single bite of food. No staff in area other than the staff working on construction who are not attentive to Residents eating and have their backs turned towards the Residents and not in visual sight of R2. Activity staff came and removed the folded linen from R2 that she had accomplished prior to getting her meal. The Activity staff did not assist or encourage the R2 to eat and left the area after briefly talking to another Resident, leaving no staff in the dining area. -At 12:51 PM, no staff in the dining area where R1 and R2 were seated. R1 was eating her meal, not seen to be alternating sips with food. R2 has not eaten any bites of food but drank some V8 juice. -At 12:56 PM, Staff came into the area and removed the plate from a Resident who left the dining area and was seated at R2's table. The Staff did not assist or encourage R1 or R2 and the staff left the area.-At 12:57 PM, Staff came into the area and removed plates where a resident had finished the meal and left the area. The Staff did not encourage or assist R1 or R2. -At 12:58 PM, Staff in the area cleaned a table of Residents that were done with meal. Did not come to R2 to assist or encourage meal. Resident had not eaten except some sips of V8 juice.-At 1:00 PM, a CNA asked R2 if she was hungry, R2 gave an unheard response and was not assisted with a bite of food. The CNA left and the Resident put her head down and closed her eyes after the CNA left.-At 1:01 PM, a Nurse comes to R1 and asked if she was done eating and said she saw she was sleeping. The Nurse leaves and R1 started to eat again. No assistance was given to R2. No staff in the (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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There were no staff in the area.-At 1:17 PM, R4's Visitor returned to the dining area. There were no staff in the area while R2 ate her lunch.-At 1:23 PM, R2 had stopped eating at 1:21 PM and had her head down. Staff came in, woke the Resident, assisted with a sip of V8 juice, put meat on the fork and fed the Resident the meat. The Staff puts another piece of meat on the fork, encouraged the Resident with another bite and lets the Resident know she will be back. The staff leave the area. -At 1:27 PM, the staff that was in at 1:23 returns, assisted R2 by putting another bite of meat on the fork and gave the Resident the bite. R2 takes the meat readily. The Staff then left the area after giving the Resident the bite of food.-At 1:28 PM, R2 took the fork and started to eat the meat on her own. There were no staff in the area.-At 1:31 PM, Staff came by and asked the Resident how she was doing, the Resident replied Good. The Staff encourage the Resident to eat and then leaves the dining area while the Resident continues to eat.-At 1:32 PM, R2 continues to eat and tried to pick out the strawberries from under the piled-on spaghetti. There were no staff in the dining area in view of the Resident.-At 1:33 PM, Staff came by R2, saw the Resident eating and said to the Resident that she would be back.-At 1:38 PM, Visitor with R4 left the dining area. R2 was interviewed and answered simple questions. The Resident reported the food was good. She was observed to be brushing off food from her lap. When asked if she was offered a shirt protector, she reported that sometimes she gets one and sometimes she doesn't and stated, didn't today. There were no staff in the dining area. R2 continued to eat.-At 1:44 PM, Activity staff came into the dining area, assisted a resident out and left the area. No other staff were present in the dining area where R2 continued to eat and had consumed strawberries with spaghetti. -At 1:49 PM, CNA D comes into the dining area, asked R2 if she was completed with her meal, removes the food portion, leaves the liquids with the Resident and leaves the area. At 1:54 PM, Resident 2 remains in the dining area with her liquids at the table. Resident 1A review of Resident 1's medical record revealed an admission into the facility on [DATE] with diagnoses that included Multiple Sclerosis, hemiplegia affecting left side, Alzheimer's disease, and dysphagia. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 11/15 that indicated moderate cognitive impairment and the Resident needed set up or clean up assistance with eating and dependent on helper for other activities of daily living, mobility and transfer. A review of R1's meal ticket revealed the following:-Safe Swallow: Sit upright for all po (oral) intake, small bites, slow rate, alternate bites/sips 1: (to)1, report coughing to nursing staff. A review of Resident 2's medical record revealed an admission into the facility on 1/13/23 with diagnoses that included Alzheimer's disease, diabetes, dementia, and dysphagia. A review of the MDS revealed a BIMS score of 3/15 that indicated severe cognitive impairment and needed setup or clean up assistance with eating and dependent on helper for most other activities of daily living. A review of R2's meal ticket revealed the following:-Meal Note: courage meals in dining room/offer cues/encouragement-Daily Note: Cut everything into bite size pieces.-Profile Note: Diet: Regular diet, regular texture. Regular/thin consistency *Meat cut up into bite size pieces. Meat cut up into bite sized pieces, per POA cut everything into bite sized pieces, no sweets, offer fruit or diet Jello.-Safe Swallow Instructions: close supervision at meals and encouragement for po (oral) intake, instruction for small bites/sips, alternating solids/liquids, slow rate. On 11/13/25 at 2:45 PM, an interview was conducted with the Administrator (NHA) of the dining observations with lack of staff in the area, lack of assistance and encouragement with meals and a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 2's meal ticket with safe swallow instructions. The NHA indicated that by the time the Resident was assisted with food, her meal would have been cold. A review of the weights for Resident 2 revealed the Resident was approximately 125 pounds about a year ago, 121 pounds three months ago, and recent weight was 116 pounds, revealing R2 had weight loss. On 11/13/25 at 3:15 PM, an interview was conducted with Unit Manager (UM), Nurse E regarding the dining observation made on the second-floor dining area for R2. The UM reported that there should be staff during dining to monitor and assist as needed. On 11/14/25 at 1:56 PM, an interview was continued from the prior day with the Umit Manager. The UM reported that the Safe Swallow Instructions meant that Speech Therapy had seen the resident and set up guidelines for safe swallow instructions, both R1 and R2 were on swallow precautions and both Residents needed supervision/monitoring in the dining area while eating. R1 should have her Broda chair at a 90-degree angle and a review of the recline of the Resident during the lunchtime meal observation on 11/13/25 was discussed. The UM was unsure what the 1:1 meant and indicated she would get clarification from speech therapy on that. The UM indicated that staff should encourage bites with sips for R1 and that staff should be monitoring the Resident while eating to keep an eye on her. The Speech Therapy recommendations for R1 and R2 were requested.A review of R1's Speech Therapy SLP Evaluation and Plan of Treatment, dated 5/29/25 revealed a referral evaluation for occasional oral pocketing during meals when tired. Assessment of overall abilities include Set-up and Supervision; Assessment Summary included, .Pt (patient) appears to be tolerating current diet at this time. SLP (speech language pathologist) did provide education to DNA/nurse on safe swallowing/compensatory strategies. R1's Kardex (patient care guide) revealed, Diet-Safe Swallow Instructions: Sit upright for all po (oral) intake, small bites, slow rate, alternate bites/sips 1:1, report coughing to nursing staff. A review of R2's Speech therapy SLP Evaluation and Plan of treatment, dated 9/19/25 revealed the Potential for achieving goals: Guarded due to decreased alertness and cognition. Recommendations included Supervision for oral intake=close supervision and Strategies included Swallow Strategies/Positions: to facility safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: bolus size modifications, lingual sweep/reswallow and alternation of liquids/solids; and Reason for Skilled Service: To assess safest and least restrictive diet to ensure maintenance of nutrition via oral intake with no evidence of airway compromise. R2's Kardex revealed, Diet-Safe Swallow Instructions: close supervision at meals and encouragement for po intake, instruction for small bites/sips, alternating solids/liquids, slow rate. A review of facility document titled, Standard Policy and Procedure, revealed, Subject: Any safe swallow suggestions will be included on each meal ticket for use by CNA (Certified Nursing Assistant), Purpose: to ensure proper feeding techniques. Procedure: 1. Safe swallow suggestions will be written by speech therapist and placed into (electronic medical record) care plan and (dietary system) for Dietary to print onto tickets. 2. Dietary will add a copy of safe swallow suggestions on each meal ticket. A review of facility policy titled, Feeding a resident, revealed, .1. Check residents meal ticket for current diet orders or safe swallowing instructions. 10. Encourage the resident to hold his glass, bread, finger foods and participate in meal as able. 11. Allow him time to chew and swallow. Follow any speech therapy orders/safe swallow instruction on the resident's meal ticket.