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	04/01/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent two unstageable pressure ulcers (a severe wound with full-thickness tissue loss, fully covered by slough or eschar, making its true depth hidden) for one resident (Resident #164) of three residents reviewed for pressure ulcers, resulting in bilateral heel pressure ulcers. Findings include.Resident #164:On 3/30/2026, at 10:45 AM, Resident #164 was propelling in the hallway in their wheelchair. There were no wheelchair pedals and the residents' heels were slightly dragging on the floor while they propelled. Resident #164 had on socks. On 3/31/2026, at 9:51 AM, a record review of Resident #164's electronic medical record revealed an admission on [DATE] with diagnoses that included neurocognitive disorder with Lewy bodies, Alzheimer's disease and Psychotic disorder. Resident #164 had severely impaired cognition and required assistance with all Activities of Daily Living. A review of the progress notes revealed 1/30/2026 14:36 (2:36 PM) . Skin Issues: #001 . Left heel . new wound . Unstageable pressure injuries presenting as deep tissue injury. Wound acquired in-house. Wound is new . Length (cm) (centimeters) 0.92 Width (cm): 1.21 Depth)cm): 0 . #002 . Right heel . Unstageable pressure injuries presenting as deep tissue injury. Wound acquired in-house. Wound is new . Length 1.92 Width 1.1 Depth 0 . 2/5/2026 10:00 IDT discussed new wounds noted last week. IDT discussed that (resident) was in bed more than usual due to influenza infection. IDT discussed that foam boots, turn schedule, and liquid protein were ordered. IDT discussed that order for multivitamin would benefit healing. IDT discussed that (resident) has been up in her wheelchair like normal this week and that alternating pressure mattress is not needed due to her return to baseline with mobility and orders for turn schedule and boots. No other changes in plan of care are needed at this time. IDT is in agreement with current plan of care. A review of the Task List Report revealed the following interventions: Hold on shoes Date Initiated 02/19/2026 Low Air Loss Alternating Pressure mattress, settings: Comfort Level: (3), Firmness: (Alternating) Date Initiated 03/13/2026 A review of the Pressure ulcer/Injury notes labeled Rt. (right) Heel revealed the following: 2/9/2026 Length (cm) 2.1 Width (cm) 2.53 Depth 0 2/16/2026 Length (cm) 3.4 Width (cm) 2,74 Depth 0 2/26/2026 Length (cm) 2.19 Width (cm) 3.12 Depth 0 3/17/2026 Length (cm) 2.51 Width (cm) 3.01 Depth 0 3/30/2026 Length (cm) 2.11 Width (cm) 2.65 Depth 0 A review of the Pressure ulcer/Injury notes labeled left heel revealed the following: 2/9/2026 Length (cm) 0.99 Width (cm) 1.64 Depth 0 2/16/2026 Length (cm) 1.56 Width (cm) 2.03 Depth 0 2/26/2026 Length (cm) 1.55 Width (cm) 1.78 Depth 0 3/9/2026 Length (cm) 1.52 Width (cm) 1.8 Depth 0 3/17/2026 Length (cm) 1.18 Width (cm) 1.17 Depth 0 3/24/2026 Length (cm) 2.64 Width (cm) 1.89 Depth 0 3/30/2026 Length (cm) 1.62 Width (cm) 1.97 Depth 0 A review of the INTEGUMENTARY FOCUS: (the resident) has the potential for impairment in skin integrity related to poor safety awareness, frail skin, side effects of medications, and incontinence. Geri gloves were trialed in [DATE], and she refused about half of the time. Staff are to anticipate resident may obtain skin injuries, like bruising and skin tears, easily. (the resident) has a history of MRSA, infection to skin. Hx of removing Geri Gloves after they are applied. Date Initiated: 06/27/2024 Revision on: 12/01/2025 ,,, Interventions/Tasks . Encourage resident to wear Prevolon boots to bilateral feet while in bed Date Initiated: 03/06/2026 Revision on: 03/06/2026 A review of the care plan WOUND CARE FOCUS (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident) has BILATERAL HEEL PRESSURE ulcer on bilateral heels, R/t pressure, Staff encourage boot in and out of bed prevalon and prafo. Date Initiated: 03/06/2026 Revision on: 03/06/2026 . Interventions/Tasks Give meds as ordered . Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations Date Initiated: 03/06/2026 On 4/01/2026, at 10:48, Nurse M was interviewed regarding Resident #164's heel pressure ulcers. Nurse M was asked if the pressure ulcers were avoidable or unavoidable and Nurse M stated, avoidable. Nurse M was asked to provide weekly wound measurements. On 4/01/2026, at 11:10 AM, the Director of Nursing (DON) was asked how Resident #164's pressure ulcers developed and the DON offered, they would follow up. On 4/01/2026, at 11:30 AM, the DON provided that Resident #164 had influenza was in bed for a week and had decreased food/fluid intake. The DON was asked what interventions they placed for Resident #164 and the DON offered, we placed the boots but then she kept rubbing her heels inside the boots so the boots were discontinued. The DON also stated that the facility tried different boots because when the resident propels in the wheelchair she at times uses her heels to assist in propelling. The DON offered, the resident is active and doesn't always want to rest in bed to elevate her heels.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings include:On 03/30/2026 at 9:36am, during the initial kitchen tour, observed can opener visibly soiled. During this observation, Culinary Supervisor A was queried on how often the can openers are cleaned and stated it's cleaned daily. On 03/30/2026 at 9:37am observed a chemical feed downstream of an atmospheric vacuum breaker in the dishwashing area. One wasting tee was observed lying inside the sink basin and another wasting tee sitting above the sink in a bin. According to the State of Michigan's 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve).According to the State of Michigan's 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.On 03/30/2026 at 9:43am Everwipe Chem-ready sanitizer bucket was tested, and the result was zero with the prepared date as 2-16-26 and use by date of 3-16-26. During this observation, Culinary Supervisor A was interviewed on what range the sanitizer solution should be kept at, and she stated 150-200 and that the buckets are supposed to be good for a month. According to the FDA 2022 Food Code, 3-304.14 Wiping Cloths, Use Limitation, Cloths in-use for wiping counters and other equipment surfaces shall be .Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114 and The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit.According to the facility's policy on sanitizer buckets, Sanitizer concentration should be read between 200-400ppm or manufacturer's recommendation. In addition, Everwipe buckets tested at least once a day and replace every thirty days unless wipes run out sooner.On 03/30/2026 at 9:46am observed mixer visibly soiled. During this observation, Culinary Supervisor A was interviewed on how often it's cleaned, and she stated it's cleaned after every use. On 03/30/2026 at 9:52am observed shredded lettuce with a best by date of 3/29 in fridge located in the cafeteria. During this observation, Culinary Supervisor A was asked what they do when food is past it's best by date, she stated it's thrown out and proceeded to throw away the chopped lettuce. On 03/30/2026 at 9:57am observed interior walls of microwave visibly soiled in the pantry room on the first floor. During this observation, Assistant Food Service Director B was interviewed on how often the microwave is cleaned and he answered it's cleaned daily. On 03/30/2026 at 10:00am observed a fan with accumulated dust on the surface blowing directly at the three-compartment sink in one east pod kitchen. During this observation, Assistant Food Service Director B was interviewed on how often the fan is cleaned, and he stated it's cleaned once a week or as needed. On 03/30/2026 at 10:18am observed a steady stream of water leaking underneath the hand sink in one west pod kitchen. According to the FDA 2022 Food Code, 5-205.15 System Maintained in Good Repair, A plumbing system shall be: repaired according to law.and maintained in good repair.On 03/30/2026 at 10:19am observed cooked mushrooms with a discard date of 3/28 in fridge in the one west pod kitchen. On 03/30/2026 at 10:22am observed milk in a cup with a lid without datemarking in fridge in one west dining area. On 03/30/2026 at 10:25am observed interior walls of microwave visibly soiled in pantry room located on two south. According to the 2022 Food Code, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	days. The day of preparation shall be counted as Day 1.According to the facility's policy on date marking, The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. and the marking system shall consist of a label, the day/date of opening, and the day/date item must be consumed or discarded. On 03/30/2026 at 10:38am observed brownish residue on the interior of a cup on the clean dish rack in two south east pod kitchen. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the facility's policy on cleaning and sanitizing food contact surfaces, During all hours of operation, visually and physically inspect food contact surfaces of equipment and utensils to ensure that the surfaces are clean. On 03/30/2026 at 12:29pm observed [NAME] C touch face with bare hand and then proceeded to use clean utensils to tray food at two north non pod tray line. According to the FDA 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and .After engaging in other activities that contaminate the hands. According to the facility's policy on handwashing for dietary employees, Wash hands: after touching hair, face, or body.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 1) Follow care-planned interventions for one resident (Resident #12) , 2) Ensure supervision for one resident (Resident #164), and 3) Ensure safety with hot liquids for one resident (Resident #91) out of five residents sampled for safety, resulting in blisters from a hot liquid and the inability to propel freely. Finding include:Resident 91 (R91): 03/30/2026 4:20 PM, an observation was made of R91 in her room sitting in their wheelchair. The Resident was observed to not be sitting upright but was slouched in the wheelchair. The Resident was working on activities on her overbed table. The Resident was interviewed but was unreliable with answers and did not engage in conversation. An observation was made of limited mobility of her arms. A review of Resident 91's medical record revealed an admission into the facility on 7/10/20 with diagnoses that included Parkinson's Disease, scoliosis, dementia and osteoarthritis. A review of R91's Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 3/15 that indicated severely impaired cognition and the Resident needed set up assistance with eating, partial/moderate assistance with oral hygiene and upper body dressing and the Resident had bilateral impairment of the upper and lower extremities. A review of R91's care plan revealed a Nutrition/Hydration Focus with an intervention dated initiated on 3/4/35 Diet-Hot liquids: Resident to use cup with lid. Resident to wear clothing protector/lap protector, Resident encouraged to be seated at lowered table/tray surface for optimal positioning, revision on 12/1/25 revealed, Diet-Hot liquids: Resident to use cup with lid, Resident to wear clothing protector/lap protector. A review of the Facility Reported Incident, Resident 91 was given hot cocoa with lid and straw. Resident was drinking cocoa but dropped the cup when trying to replace it to the dining room table. It fell in her lap, causing 1 blister to her right leg and 2 blisters to her left leg. Resident was removed to her room and treated for pain/burning . The Investigation Summary was reviewed and revealed the incident occurred on 11/30/25 at 4:00 pm, .It was observed via video footage (no witnesses) that the resident attempted to place the cup back on the table after taking a drink and it didn't make it securely back on top of the table. Upon review of practices within the facility the IDT (Interdisciplinary team) determined that the temperature log that the kitchen is utilizing to log the temperatures of hot liquids being served to residents is within range and appropriate. However, the log does not show a time at which the temperatures are being recorded. The log is updated with a time column to log. Further, the CNA (certified nursing assistant) who served the resident her hot chocolate did not provide the resident with a clothing/lap protector. She was issued an education for safety. On 3/31/26 at 4:06 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident 91 spilling hot chocolate on her legs causing blisters to form. The DON reported that the Resident had missed the edge of the table when she went to put the cup back on the tabletop. Staff were right around the corner, and they had removed her clothing right away. When asked where the CNA got the hot water from, the DON explained that the staff had reached over and grabbed it out of the kitchen window, it had not been temped by the cook yet and the hot water carafe had not been cooled yet. The DON explained that the dietary staff was around the back and not right there. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON reported that the Resident had not been given a shirt protector or lap protector. The DON indicated education given to the CNA but was unsure if all staff had an inservice. The DON was asked if they did any audits to monitor for compliance and reported they did not do any audits. The DON reported that the blisters healed and there had not been any issues with infection. A review of the facility policy titled, Safe Serving Temperatures for Hot Liquids, revealed, Policy Statement, It is the policy of this facility to provide residents their desired drink preferences with respect given to the safe temperature at which hot liquids should be served. This policy is aimed at the served temperature of hot liquids and not the temperature for which they are brewed or derived. Policy Explanation and Compliance Guidelines: 2.Dietary staff, hold and monitor all hot liquids within the kitchen until safe serving temps are reached and recorded. Once safe serving temperatures are reached, dietary staff make the drinks available for other floor staff to assist in serving residents. 5. Hot liquids/drinks prepared outside of dietary kitchens, such as the unit pantries, shall be temperature checked by the person serving the drink and within the safe serving temperature range (120 (degrees) – 140 (degrees)) before serving to the resident. 6. If poured coffee or hot liquid exceeds 140 (degrees), the drink/carafe shall endure a cooling period, within the kitchen or pantry, until temperatures are within range for safe serving. 8. All residents are assessed for their ability to handle containers and consume liquids. Residents with difficulties will receive appropriate supervision and use of assistive devices in order to consume liquids. Residents with difficulties will receive appropriate supervision and use of assistive devices in order to consume hot liquids. Interventions will be individualized and noted on the resident's plan of care. Interventions include, but are not limited to: .d. Clothing protector/Neck napkin. Resident #12: On 3/30/2026, at 10:43 AM, Resident #12 was in their wheelchair. They were pounding their right hand on their wheelchair arm hard. On 3/30/2026, at 11:44 AM, a record review of Resident #12's electronic medical record revealed an admission on [DATE] with diagnoses that included Dystonia (neurological movement disorder), schizoaffective disorder and Dementia. Resident #12 had severely impaired cognition and required extensive assistance with Activities of Daily Living. A review of the INTEGUMENTARY FOCUS: . Per POA (power of attorney) resident bruises easily, and due to her dystonia resident has increased potential for bruising and skin tears . A review of the care plans revealed no intervention for their potential bruising. A review of the Physician orders revealed . Positioning/supportive Device: arm rolls to wheelchair arm rests No directions specified . Active Revision Date 3/9/2026 A review of the Kardex revealed . Supportive/Adaptive Equipment: arm rolls to wheelchair arm rests . A review of the progress notes revealed 3/7/2026 17:45 (5:45 PM) Incident Note Note Text: CNA brought to writer's attention that resident had some bruising to her arm. Writer assessed resident and noted two bruised to the upper right bicep area. One bruise approximately 2cm (centimeters) in diameter and the other approximately 1.5 cm in diameter. Bruising bluish/purple in color. Resident denied and pain to the area. Resident unable to give description of how bruises were obtained. Writer noted the placement of the bruises. No catastrophic reactions were noted when writer identified the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bruises. Resident is very active in her wheelchair all day long. An effect of resident's demeaner is to periodically pound on wheelchair heavily. Writer called POA to notify them of the bruising. Writer placed on physician's board for notification. On 3/30/2026, at 1:31 PM, Resident #12 was in their wheelchair. There was no padding to their bilateral wheelchair arms. Resident #12 was pounding on their wheelchair arms. On 3/31/2026, at 10:49 AM, Resident #12 was in their wheelchair. There was no padding to their bilateral wheelchair arms. On 3/31/2026, at 2:14 PM, Unit Manager (UM) P was interviewed regarding Resident #12's intervention of arm rests to their wheelchair. Unit Manger P was asked why for two days the padded arm rests were not available to Resident #12 and UM P provided they would look into it. On 3/31/2026, at 2:27 PM, a record review of Resident #12's electronic medical record along with UM P revealed the arm rests were added as an intervention for their previously noted arm bruising on March 7. UM P offered, that the resident may have removed the arm rests and will follow up. On 3/31/2026, at 3:31 PM, UM P offered, the arm rests pads were not found because the resident is all over the building. UM P was asked how they would ensure the arm rests pads were available for Resident #12 and UM P offered, she did have them on early this morning but they were not located. On 4/01/2026, at 8:21 AM, the DON was interviewed regarding the lack of arm rests noted to Resident #12's wheelchair for their bruising and the DON offered, she takes them off. On 4/01/2026, at 8:42 AM, Resident #12 was in their wheelchair and there was an arm rest pad noted to their right side only. The left side of the wheelchair did not have a pad placed. The resident was observed pounding on the attached wheelchair pad with their right hand. On 4/01/2026, at 8:50 AM, Resident #12 was observed pounding hard to left wheelchair armrest. Resident #164: On 3/30/2026, at 10:50 AM, Resident #164 propelled in their wheelchair into room [ROOM NUMBER] (not their room). Resident #164 propelled to the foot of the bed and appeared to get their wheelchair stuck on the foot board. Resident #164 was mumbling and was unable to answer any questions. There was a nurse in the hallway near a medication cart near room [ROOM NUMBER]. There was another staff member that exited room [ROOM NUMBER] and walked towards the day room. On 3/30/2026, at 10:55 AM, Two staff members were observed across the hallway near room [ROOM NUMBER] and walked in the opposite direction of room [ROOM NUMBER]. On 3/30/2026, at 11:02 AM, Nurse L remained in the hallway near room [ROOM NUMBER]. Resident #164 remained in room [ROOM NUMBER] and was unable to move their wheelchair forward or backwards. Resident #164 was mumbling while attempting to move their wheels with a scowl to their face. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/30/2026, at 11:04 AM, two staff members (hospitality aides) walked to the end of the hall to the window and did not notice Resident #164 stuck in room [ROOM NUMBER]. On 3/30/2026, at 11:08 AM, Hospitality aide N walked toward room [ROOM NUMBER] turned and noticed Resident #164 stuck in room [ROOM NUMBER]. Hospitality aide N assisted Resident #164 out of the room and into the hallway. On 3/31/2026, at 9:51 AM, a record review of Resident #164's electronic medical record revealed an admission on [DATE] with diagnoses that included neurocognitive disorder with Lewy bodies, Alzheimer's disease and Psychotic disorder. Resident #164 had severely impaired cognition and required assistance with all Activities of Daily Living. On 3/31/2026, at 10:52 AM, CNA O was asked where Resident #164 was and CNA O offered, most likely down on the southside (the south end of the building).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to eliminate dead end plumbing and ensure appropriate backflow prevention was installed at plumbing fixtures, resulting in the potential for contamination to the water supply, affecting all residents. Findings include: On 03/31/2026 at 9:48am observed a dead end water line in the one east pod kitchen area. During this observation, Maintenance and Housekeeping Manager D was interviewed on what the water line was used for, and she stated the line used to feed into an old juice machine, but it was removed about a month ago and that the unused water line needed to be removed. On 03/31/2026 at 10:16am observed dead end water line that was plumbed through the wall near the hand sink in the soiled utility room on two west. During this observation, Maintenance and Housekeeping Manager D was asked what the water line was used for and she stated she wasn't sure. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Eliminate dead legs, which are sections of no- or low-water flow. On 03/31/2026 at 10:44am observed outside spigot with spray nozzle downstream of hose bib vacuum breaker in one south west courtyard. On 03/31/2026 at 10:47am observed outside spigot with spray nozzle downstream of hose bib vacuum breaker in west courtyard. On 03/31/2026 at 10:50am observed outside spigot with spray nozzle downstream of hose bib vacuum breaker in east courtyard. On 03/31/2026 at 11:00am observed outside spigot with spray nozzle downstream of hose bib vacuum breaker at front entrance. According to the State of Michigan's 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve).

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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 residents were treated in a respectful and dignified manner to ensure toileting assistance for one resident (Resident #162), and provide dining assistance in the 1-South dining room, resulting in Residents having soiled briefs due to call lights not being answered timely, the potential for weight loss, and residents' feelings of frustration. Dining Observation: Residents in the 1st Floor South Dining Room On 3/30/2026 at 12:09 PM, during an observation in the 1st floor South dining room, a group of 10 residents were observed sitting in the dining room, for the lunch meal. Per Nurse Q, the meal usually started at 12:00 PM. Two Nurse Aides R and S were delivering the drinks to the residents. The aides were asked how many staff were usually assigned to assist the residents with their meals in the dining room and hallways and they said Two. The meal was served beginning at 12:10 PM.-The two aides assisted in passing trays to the residents and then assisted the residents with eating. There were 3 residents who sat without eating, while one resident received assistance. Their food was left uncovered. It had been left sitting open and untouched for greater than 10 minutes. Then 1 aide went to the hall to pass trays, and 1 aide was left to assist the residents in the dining room. She started to feed 2 residents at once, then rose and took a resident down the hall to go to the restroom. On 3/30/2026 at 12:33 PM, during the 1st floor South dining room observation, no staff were in the dining room observing, monitoring or assisting the 10 residents. The [NAME] was in the kitchen. 1 resident had his head down near his meal tray. Two additional residents sat without touching their trays or receiving assistance; their meal trays remained open throughout. The [NAME] came out of the kitchen to try to assist one of the residents. On 3/30/2026 at 12:37 PM, Nurse Q entered the dining room, sat between two residents and began feeding them at the same time. For some of the residents their food had been sitting out for almost 30 minutes. The aides were in the halls assisting other residents. On 3/31/2026 at 12:35 PM, the lunch meal was observed. There was a Charge Nurse, and 3 nurses aides present in the dining room, to assist the residents. On 3/31/2026 at 1:45 PM, the dining observations were reviewed with the Director of Nursing. Discussed with her the number of residents sitting without assistance or monitoring in the 1st Floor South dining room on 3/30/2026 during the lunch meal. She said there should have been staff present in the dining room. Resident #162: R162 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following cerebral infarction that affects the full right dominant side, (continued on next page)

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	04/01/2026

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypertensive heart disease and chronic kidney disease. On 03/30/2026 at 10:20AM, an interview was conducted with R162. R162 was asked if the facility answers her call light in a timely manner. R162 stated, it takes a long time to get the call light answered and I only turn it on if I truly need something. R162 stated, the regular aides see my light and they come down quickly. The newer aides see my call light on and they take forever to get here. The other day an aide came into my room and was trying to get the bucket on my commode but couldn't. The aide then threw the bucket down and left the room frustrated. I really had to go to the bathroom, I thought the aide was going to come back and help me and they didn't and consequently I messed my pants. I started to cry, I was very upset and eventually a staff member came by to change my brief and clean me up. I told someone about it but never got an apology at all. On 04/01/2026 at 10:48AM, an interview was conducted with the Director of Nursing (DON). The DON was asked if they were aware of the concern that R162 had. The DON stated, I know this happened on second shift. R162 turned on her call light, the aide entered the room and then left without completing the care. I was told that the aide left the call light on for the other aide to come down and help. However, no one came back. On 04/01/2026 at 11:39AM, the DON indicated the facility investigated the situation. The DON stated that on 03/192026, R162's aide was giving a shower to another resident, the Assistant Director of Nursing (ADON) asked the hall partner to go help R162 and she went and answered the call light, but by that time R162 was upset and didn't want to be touched. The nurse on the floor went in at that time and was able to complete the care. R162 stated to social worker and unit manager that her call light was on for over 45 minutes while she waited to be toileted and then she just eventually went in her pants and then began yelling for help. R162 was noted to be very tearful at the time. On 04/01/2026 at 11:48AM, a review of the call light log from 03/19/2026 revealed that R162's call light was on for 42 minutes at 4:26PM and then for 28 minutes at 5:15PM On 04/01/2026 12:09 PM Interview with [NAME], LPN. Her aide was giving someone a shower, I know she was embarrassed and tearful that she went in her pants. Another aide went down to help but R162 didn't want her help. I have a good rapport with her and was able to clean her up. I know this happened sometime between 4:30-6:30pm. I don't know how long her call light was on but she was incontinent of stool and tearful.

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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 develop and implement a comprehensive care plan for one resident (Resident (#56) of 1 resident reviewed for smoking, resulting in Resident #56 lacking a care plan to identify where to store the resident's smoking materials including a lighter. Findings Include: Resident #56:Smoking A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #56 was admitted to the facility on [DATE] with diagnoses: History of a stroke, left sided weakness, history of traumatic brain injury, COPD, Nicotine dependence, with withdrawal. Anxiety, Depression, peripheral vascular disease, chronic pain syndrome. The MDS assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status/BIMS score of 15/15, needed some assistance with care and used a motorized wheelchair. On 3/30/2026 at 9:30 AM, during the Entrance Conference with the Administrator and Director of Nursing/DON, the Administrator said the facility was a Non-Smoking Campus, but Resident #56 left the campus to smoke. When asked where he went, the Administrator said he had an electric wheelchair and left the premises in his wheelchair and went down the road. When asked who was responsible for the resident's smoking materials, cigarettes and lighter, the Administrator said sometimes his family brought the resident cigarettes, but the facility did not keep them for the resident. The Administrator said he did not know if the resident had a lighter or how he lit the cigarettes. On 3/31/2026 at 11:30 AM, Resident #56 was interviewed in his room. He was lying in bed watching TV. His electric wheelchair was in his room next to the bed. The resident was asked about his wheelchair, and he said he used his wheelchair inside and outside of the facility. The resident was asked if his wheelchair ever ran out of power and he said it had. He said someone would stop on the road to help him, a passerby would either bring him back or notify the facility and they would send a truck to pick him up and the wheelchair. The resident was asked if he was able to call for assistance and he said he no longer had a phone. During the interview with Resident #56 on 3/31/2026 at 11:30 AM, the resident was asked about smoking, and he said he smoked but he would go off the facility property to smoke. When asked where he kept his cigarettes, he said he didn't currently have any. The resident was asked how he lit his cigarette and he stated, With a lighter. The resident was asked where he kept his lighter and he looked at his bedside dresser. The lighter was lying on top of the dresser. A review of the Care Plans for Resident #56 indicated the following: Mood/Behavior: (Resident #56) is at risk for depression r/t (related to) rules and policies of facility. He has times of smoking at entrances and in building with education. date initiated 6/4/2024 and revised 1/27/2026 with Interventions including: When observed smoking, remind him this is a non-smoking facility/campus. Smoking is to be off campus, date initiated 1/27/2026. There was no mention of the resident carrying cigarettes or a lighter in the facility. (Resident #56) has Emphysema/COPD related to smoking, was active smoker on admission. Continues to smoke on grounds despite education of no smoking policy, date initiated 9/10/2024 and revised 1/22/2026. The interventions did not mention the resident smoking or that he had cigarettes and a lighter. The Care Plans did not address the resident having smoking materials in his possession in the building. On 3/31/2026 at 4:32 PM, the DON was interviewed about the resident having a lighter on his countertop in his room. She said he had a lock box in his room and was supposed to use it for the lighter when he was not in his room. Reviewed the resident was sleeping soundly earlier and did not stir when the door was opened and his name was called on two separate instances. It was observed during the survey that several residents were observed wandering in the hallways and into other residents rooms in the facility Also reviewed the care plan did not mention anything related to storing the residents lighter in a lock box. On 4/1/2026 at 10:33 AM, the Administrator was interviewed about Resident #56 smoking and having smoking materials in his possession. He said the facility did not manage the resident's cigarettes or (continued on next page)

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	235058	A. Building B. Wing	04/01/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lighter. Reviewed with the Administrator the lighter was not secured in the resident's room and could be accessible to other residents, who might be confused. He said the resident had been observed smoking on facility grounds and in the building and they had been working with the resident and educating him about the smoking policy. Reviewed there was no Care Plan that addressed the safety involved with storing the resident's cigarettes and lighter. A review of the facility policy titled, Smoking Policy, date updated 9/4/13 and reviewed 9/23/2025 provided, Policy Statement: To provide an environment that promotes good health, wellness and prevention, to recognized the harmful effects associated with smoking. It is the policy of (the facility) that all tobacco related products are prohibited in all buildings and on all grounds owned, operated or under agreement with (the facility). The only exception is: smoking is allowed in the personal vehicles. Individuals covered by this policy include, but are not limited to, Employees, Residents Visitors. Violation of this policy will lead to corrective action up to and including discharge. The policy did not address where the resident would safely store his cigarettes or lighter.

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	235058	A. Building B. Wing	04/01/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise care plans for psychotropic medications for one resident (R2) of five residents reviewed for psychotropic medications resulting in an inaccurate care plan. Findings include: Resident #2 (R2):R2 is 90yrs old and originally admitted to the facility on [DATE] with diagnoses that include dementia, major depressive disorder, anxiety disorder and chronic kidney disease.On 04/01/2026 at 8:56AM, a medication regimen review (MRR) was conducted in the electronic medical record (EMR).On 04/01/2026 at 9:00AM, record review of the physician's orders revealed that R2 is prescribed, Seroquel 25mg, one tablet by mouth at bedtime, dated 2/12/26 and Remeron 15mg, once daily, with a dose change noted on 6/11/25.On 04/01/2026 at 9:05AM, record review revealed a care plan is present for psychoactive medication, initiated on 03/13/2024, last revised on 04/15/2025. The care plan references Remeron and that a Gradual Dose Reduction (GDR) was attempted on 4/7/25. The care plan does not reference the use of Seroquel. The care plan has not been updated since 4/15/25.On 04/01/2026 at 10:34AM, an interview was conducted with the Social Worker (SW) E. SW E was asked who is responsible for updating care plans for psychotropic meds. SW E stated, the nurses, the other social workers and I can update the care plans. SW E was asked when care plans are updated for psychotropic meds. SW E stated that we updated them quarterly and as needed. SW E stated, as needed includes GDR's, dose changes and medication changes. SW E was asked if the care plan should have been updated with the change in dosage and new medication. SW E stated that it should have been updated for the Seroquel at minimum.On 04/01/2026 at 10:54AM, an interview was conducted with the Director of Nursing (DON) The DON was made aware that the care plan had not been updated. The DON stated that the care plan should have been updated with the new medication that was added. Review of the policy titled, Interdisciplinary Care Plan, revealed,Policy Interpretation and Implementation3. The Unit manager will review the information found in each care plan section looking at the care that has been provided related to physician orders, labs, diagnostic testing, current medical status, etc. in order to assure continuity of care. Any issues found will be discussed with the appropriate interdisciplinary care plan team member and if necessary, taken to the physician and resident/family seeking direction for future plan of care. 4. For quarterly/annual/CIS care plan updates, the Interdisciplinary care plan team will review their goals and approaches for appropriateness and request any necessary changes by notifying the Floor Coordinator. The Unit manager will discuss the goals/approaches with the physician and make any necessary changes in the electronic care plan.

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	235058	A. Building B. Wing	04/01/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review the facility failed to ensure that professional standards of practice were followed with the assessment, monitoring, documentation and timely physician notification of a medication error for one resident (Resident 131) who had been administered in error a Norco 5mg/325 mg (an opioid pain medication of a combination of acetaminophen and hydrocodone), of one resident reviewed for a change in condition. Findings include:Resident #131 (R131):On 3/30/26 at 9:46 AM, an observation was made of Resident 131 lying in bed. The Resident aroused to a knock on her doorway. The Resident was asked questions but did not answer questions reliably and did not engage in conversation. A review of Resident 131's (R131) medical record revealed an admission into the facility on 5/23/18 with diagnoses that included Alzheimer's disease, and dementia. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 4/15 that indicated severely impaired cognition. A review of the Resident's allergies revealed an allergy to codeine and sulfa antibiotics. Further review of the medical record revealed progress notes of medication error that included:-1/31/26 at 11:57 PM, Writer attempted to call both POAs (power of attorney). No response.-2/1/26 at 9:02 AM, Attempted to call POA in regard to medication error, no answer.-2/1/26 at 4:44 PM, Writer contacted POA (Name). Writer notified POA of situation and actions taken. POA with no questions or concerns and thanked writer for the call.-2/1/26 at 6:04 PM, PA notified. No new orders at this time.A review of the Medication Administration Record (MAR) revealed no documentation of the medication that had been administered. On 3/31/26 at 3:55 PM, an interview was conducted with the Director of Nursing (DON) of the medication error with Resident 131. The DON was asked what the medication error was and reported the Nurse had given Norco (narcotic pain medication that contained acetaminophen and hydrocodone) that was supposed to be given to another resident. Resident 131 had an allergy to codeine. The medical record was reviewed with the DON. The review revealed a lack of documentation about what medication was given. The MAR and progress notes lacked documentation of the medication that was administered to the Resident. The DON indicated that the medication should be documented if it had been given. The PA (physicians assistant) was documented as notified on 2/1/26 at 6:04 PM in the progress notes and the DON indicated it was not timely and was unsure, looking at the documentation, if the practitioner was notified of the medication error prior to the next day at 6 pm. The documentation monitoring for signs and symptoms of allergic reaction was reviewed, but the documentation lack assessment of receiving the narcotic medication like lethargy. The DON reported they should be monitoring side effects of narcotic medication as well as monitoring for allergic reactions.

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	235058	A. Building B. Wing	04/01/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that an Enteral nutrition (tube feeding/nutrition through a feeding tube into the stomach or intestines) formula was identified when ordered for one resident (Resident #23) of 1 resident reviewed for enteral nutrition, resulting in the potential for Resident #23 to not receive the appropriate Enteral formula.Findings Include: Tube Feeding Resident #23: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #23 was admitted to the facility on [DATE] with diagnoses: history of a traumatic brain injury, epilepsy, quadriplegia, dysphagia (difficulty swallowing), gastrostomy tube (feeding tube into the stomach), and hearing loss. The MDS assessment dated [DATE] revealed the resident had a memory problem and needed assistance with all care. Section K Swallowing/Nutritional Status from the MDS assessment indicated the resident had a feeding tube and received his nutrition and fluids via the feeding tube. On 3/30/2026 at 11:37 AM, Resident #23 was observed sitting in a Broda chair. A tube feeding pump and syringe were in the room; the pump was not on. The resident was not receiving any enteral/tube feeding at that time. The resident was alert, but unable to answer questions. A review of the physician orders for Resident #23 identified the following: Enteral Feed Order two times a day Enteral feeding formula 1.5 cal per cc, 4 cans to equal 948cc, Give 948cc at 79cc/hr via Kangaroo E pump. Flush bag 565cc water at 48cc/hr. Feed time-ON at 6 pm off at 6 am- 12 hours- or until completion, start date 10/21/2025 at 1800 (6:00 PM). A review of the March 2026 Medication Administration Record/Treatment Administration Records (MAR/TARs) for Resident #23 revealed the following: Enteral Feed Order two times a day Enteral feeding formula 1.5 cal per cc, 4 cans to equal 948cc, Give 948cc at 79cc/hr via Kangaroo E pump. Flush bag 565cc water at 48cc/hr. Feed time-ON at 6 pm off at 6 am- 12 hours- or until completion, start date 10/21/2025 at 1800 (6:00 PM). Enteral Feed Order in the afternoon Give 1 unit Enteral feeding formula 1.5 cal per cc 237 cc via G-tube one time a day to equal 237cc for nutrition. Give 1 237 cc can bolus via G-tube, Give 100 cc total free water flush: 50cc before and after bolus feed at 2pm, start date 12/14/2025. There were also several additional orders for water administration via the feeding tube on the MAR/TAR for March 2026. A review of the Kardex for Resident #23 provided the following: Eating/Nutrition: Diet-Feed with license staff only (Nurse only to feed tube feeding). Diet Enteral feeding formula 1.5 cal per cc, 4 cans to equal 948cc at 79cc/hr. Give 1 unit Enteral feeding formula 1.5 cal per cc 237 cc via G-tube one time a day. A review of the Care Plans for Resident #23 identified the following: Enteral Feed- (Resident #23) requires tube feeding related to diagnosis of Dysphagia and history of (TBI) traumatic brain injury, date initiated 10/13/2025 and revised 3/27/2026 with Interventions including: Enteral feeding formula 1.5 cal per cc, 4 cans to equal 948cc. undated; Give 1 unit Enteral feeding formula 1.5 cal per cc 237 cc. date initiated and revised 12/14/2025. During a review of the physician orders, MAR/TARs for March 2026, Kardex and Care Plans for Resident #23, there was no identification of the type or brand of enteral nutrition the resident was to receive. A review of the Nutrition Risk Assessment dated locked 3/26/2026 for Resident #23, identified . Tube feeding can be a risk to the resident as there is potential for aspiration, infection at tube site, intolerance to tube feeding or formula, fluid imbalance. Enteral feeding formula 1.5 cal per cc. There was no mention of the specific enteral feeding formula the resident was to receive. On 3/31/2026 at 11:45 AM, Nurses G and H were interviewed about Resident #23's enteral feeding formula. Nurse H went to a cupboard at the nurses' station and removed a container of Jevity 1.5 enteral nutrition 237 cc per carton. She said that it was the formula that Resident #23 received. Next to the box with the Jevity 1.5 was another box with a different brand of enteral feeding formula. During the interview with Nurses G and H, Nurse G showed the physician order for enteral nutrition for Resident #23. It did not say what Brand of formula was to be used; it said enteral tube feeding 1.5. Nurse H showed the Medication Administration Record/MAR for (continued on next page)

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	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 for March 2026 and it said the same thing. There was no mention of the specific formula or therapeutic substitution to provide to the resident. On 3/31/2026 at 12:02 PM Nurse Manager I was interviewed about the enteral nutrition order for Resident #23. She said at one point Jevity was in short supply and they had to substitute with other brands and stated, So we bought other brands. We've had Jevity for a while now and we haven't changed the order back. The Nurse Manager I said the dietary department helped with the orders and no specific brand was ordered. She said Resident #23 received the containers of 237 ml Jevity 1.5. On 3/31/2026 at 1:30 PM, the Director of Nursing was interviewed and said she was working with the nurses to ensure a physician order was in place for the specific enteral nutrition Resident #23 was to receive. A review of the facility policy titled, Tube Feeding Administration, updated 3/14/2022 and reviewed 9/15/2025 provided, Policy Statement: To provide a concise approach for administering and documenting tube feedings. 1. Read tube feeding orders and gather appropriate equipment. If using an E-Pump Set or E-Pump Set with flush bag, nurse will prepare this using the prescribed amount and type of tube feeding solution. Label the tube feeding bag with the resident's name, date, time, feeding instructions (includes name and strength of formula and water amount.)

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	235058	A. Building B. Wing	04/01/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that an oxygen administration and care plan was updated for one resident (Resident #1) of one resident reviewed for oxygen administration, resulting in an empty oxygen tank and low oxygen saturations. Findings include. Resident #1: On 3/30/2026, at 9:55 AM, Resident #1 was sitting in their wheelchair with their overbed table in front of them. Resident #1 appeared anxious and was crying. Resident #1 had oxygen on via nasal canula that was set to 2 liters via the wall oxygen. On 3/30/2026, at 11:30 AM, a record review of Resident #1's electronic medical record revealed a readmission on [DATE] with diagnoses that included Congestive Heart Failure, Dementia and heart arrythmia. Resident #1 had severely impaired cognition and required assistance with all Activities of Daily Living. A review of Physician orders revealed . Administer Oxygen @ 3 Liter/min Via Nasal Canula with humidification on (24 hrs/day) . Start Date 3/21/2026 . A review of the CARDIOVASCULAR FOCUS care plan revealed . OXGYEN SETTINGS: O2 via nasal prongs @ 2liters On at BED (HS) off in AM/Apply if resident is napping. Humidified Continuous. Date Initiated: 03/15/2023 Revision on: 03/15/2023 . A review of O2 Sats Summary revealed . 3/21/2026 14:41 (2:41 PM) 79.0 % Method Room Air . On 3/30/2026, at 1:55 PM, Resident #1 was sitting in their wheelchair in their room. They were hooked to the oxygen tank that was hanging on their wheelchair. The oxygen dial was noted to be in the red zone. Resident #1 appeared anxious and short of breath. On 3/30/2026, at 1:57 PM, an observation along with Nurse K of Resident #1's oxygen saturation was conducted. Resident #1's oxygen saturation was 79%. Nurse K placed the oximeter onto another finger and the saturation rate was 80%. Nurse K hooked Resident #1 to the wall unit and turned the oxygen rate up to 3 liters. Resident #1's oxygen saturation rose to 92%. On 3/30/2026, at 4:11 PM, Resident #1 was resting in their recliner. Their nasal canula was off and resting on their lap. Their call light was on. Nurse J entered and was asked to obtain an oxygen saturation. The result was 86%. Nurse J placed Resident #1 on the oxygen tank. CNA O assisted the resident to the bathroom. Resident #1 appeared anxious. On 3/31/2026, at 10:35 AM, Resident #1 was sitting in their wheelchair. Their oxygen was supplied by the wall unit at 3 liters. Resident #1 appeared calm and smiled. On 3/31/2026, at 1:13 PM, Nurse J was asked if Resident #1 removes their oxygen and Nurse J stated, she took it off three times during lunch. On 4/01/2026, at 8:28 AM, The Director of Nursing (DON) was asked how they ensure Resident #1 has their oxygen on and the DON offered, we put it on when we notice it's off. The DON was alerted the oxygen tank was empty and Resident #1's oxygen saturation was at 79% and the DON offered, that shouldn't have happened.

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	235058	A. Building B. Wing	04/01/2026

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to operationalize care-planned interventions for behaviors for one resident (Resident #74) who wandered through the unit propelling their wheelchair, going into other residents' rooms, and displacing items of other residents, of one resident reviewed for mood/behaviors. Findings include:Resident 74 (R74):On 3/30/26 at 10:23 AM, observations were made on the dementia unit of the facility. An observation was made of R74 in a wheelchair, propelling herself at a fast pace, up and down the hallway. R74 was observed going in and out of resident rooms, going from one room and going across the hall to another room and proceeded to go in multiple rooms. R74 was observed to be going into other rooms where other residents were in. At one point, a resident was walking out of her room and R74 was going into the room, the other resident was able to sidestep fast enough not to collide with R74 in their wheelchair. Staff were in the area but did not intervene with the Resident going in and out of other resident rooms. At one point, the Resident was seen picking up items on a tray that was next to a resident sleeping in bed. A Staff, talking to a resident in the hallway, was alerted to R74 rearranging items on the meal tray of the other resident. R74 continued to wheel up and down the hall and in and out of other rooms. Another observation was made of a resident talking to staff in the hallway with her back turned to where R74 was propelling herself. R74 propelled up to the Resident standing and staff were able to stop the wheelchair before it came into contact with the other resident. The staff turned around R74 and R74 proceeded to propel up and down the hallway and in and out of rooms. The Resident was not observed to be redirected by staff to attend the activities in the common area. On 3/31/26 at 11:50 AM, an observation was made on the dementia unit of R74 propelling herself in the hallway and in and out of other resident rooms. R74 was observed to take a covered plate from room [ROOM NUMBER]-2 where a resident was in bed. R74 took the covered plate across the hall to room [ROOM NUMBER] and placed it on the bed. Staff were in the area and took the covered plate out of room [ROOM NUMBER] and were informed by the surveyor that it came from 174. The staff did not redirect R74. R74 did not have a busy apron or activity mat in her room, in the hallway, in the common area or with her. The Resident was not offered a tactile or soft item to hold or redirected to activities going on in the common area. A review of Resident 74's medical record revealed an admission into the facility on 3/2/22 with diagnoses that included Alzheimer's disease, dementia, anxiety disorder, and mood disorder. A review of the resident's Minimum Data Set assessment revealed the resident was moderately impaired for cognitive skills for daily decision making, was dependent on a helper for activities of daily living and used a wheelchair that was used manually by the resident. A review of R74's Kardex revealed: Intervention and Behavior Plan: Encourage [NAME] to have busy apron when up in wheelchair. When observed entering other resident rooms- re-direct to her room or common area and distract with activity, offer tactile and soft items for resident to hold. A review of R74's care plan revealed:-Safety Focus: . (R74's name) has been noted to propel herself in wheelchair with feet and she utilizes her trunk to get momentum by flinging her chest forward. Revision on 5/30/25. The care plan lacked interventions on safety for the resident or other residents in regards to potential accidents with other residents/staff or items in the hallway.-Behavior/Mood: (Residents name) wanders/enters other rooms and has rare occasion of refusing care r/t (related to) Dementia, psychotic disorder, mood disorder, and anxiety disorder, with an intervention When observed entering other resident rooms- redirect to her room or common area and distract with activity, offer tactile and soft items for resident to hold.-ADL (activities of daily living) Focus, with interventions that included, Intervention and Behavior Plan: Encourage (R74) to have busy apron when up in wheelchair, revision on 1/29/25.-Activities Focus: (R74) is dependent on staff for activities, cognitive stimulation, and social interaction d/t (due to) Alzheimer's disease, dementia with psychotic disturbance, anxiety, and (continued on next page)

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	04/01/2026

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hearing loss. Interventions included, (R74) needs assistance/escort to activity functions, revision on 1/12/24; Encourage involvement in activities. (R74) activities of past interest are: spiritual activities, pet/dog visits, intergenerational activities, caring for baby dolls, flower activities, simple jigsaw or word puzzles, games, looking at catalogs or shopping at the General Store, time outdoors in nice weather, watching TV, food events, beauty and grooming activities, revision on 11/14/25; Offer tactile and soft items for resident to hold, revision on 2/10/23. A review of R74's Task: Behavior Monitoring and Interventions revealed the following:Dated 3/30/26 the area No Behaviors Observed was marked at 06:59, 14:59 and 22:12. Dated 3/31/26 the area No Behaviors Observed was marked at 06:59, 14:59 and 21:23.There was a behavior of Entering Other Resident's Room/Personal Space available in the documentation to monitor for but was not identified as a behavior that was identified on 3/30 and 3/31. On 3/31/26 at 1:30 PM, an interview was conducted with Activities U regarding R74's care planned interventions. When asked about the busy apron, the Activities staff reported the resident has two activity blankets that they use with her. When asked where they were, they stated, They are not out right now. The Activities staff went to a storage area off the hallway. The room had many activity supplies stored. The Activity staff got a bin down and stated, When they come back form laundry, they put them in there. When asked how long they have been stored in the bin, the Activity staff was unsure when they were out last for R74. On 3/31/26 at 2:11 PM, an interview was conducted with the Unit Manager, Nurse (UM) T regarding Resident 74's behaviors and care planned interventions. The safety of residents was asked about with the behavior of R74 propelling at a fast pace through the unit and reviewed the observations made. The UM reported that the Resident should be redirected by staff and that there has not been any accidents that she was aware of. The Unit Manager reported they had tried to use the yellow banners that go across the room doors but that did not stop the resident due to her being able to take them off the doorways. The UM reported that staff should be redirecting when they notice it. The UM indicated that touching other residents' food was an issue and stated, They should be encouraging her not to touch other peoples' foods. When asked about the busy apron and activity blankets, the UM indicated they should be out for the Resident to use and redirected to activities when activities are going on. A review of facility policy titled, Managing Resident with Anxiety/Aggression, revealed, .Policy Interpretation and Implementation: .8. Offer music, TV, video, exercise, card playing, busy box or any activity of enjoyment that you may be able to engage resident in. 10. If resident is independently mobile, either ambulating or propelling w/c (wheelchair), and remains in anxious state, provide one on one intervention until resident has calmed down. Follow behind them (sometimes being in their view continues to cause distress) and make sure they remain safe and others are out of harms way.