STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235062	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandvue Medical Care Facility	1728 South Peninsula Road East Jordan, MI 49727

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor and record accurate weights per standard practice of care for one Resident (R1) of three residents reviewed for weight loss. This deficient practice resulted in R1 having a significant weight loss with no interventions. Findings include: This citation pertains to intake 2690422Review of R1's Electronic Medical Record (EMR) revealed admission to the facility on 9/25/25 with diagnoses including Alzheimer's disease. R1's Care Plan revealed R1 was independent with cueing and supervision as needed. R1 received a 3/15 on the Brief Interview for Mental Status (BIMS) in September 2025, indicating severe cognitive impairment. Review of the Facility Reported Incident read, in part, On December 3, 2025, the resident was found to have a 25.5 lb. (pound) weight loss. Upon further investigation, it was discovered the same staff member had charted weights on this resident for the last 8 weekly weights .Staff recorded inaccurate weights for a resident, resulting in missed significant weight loss. The staff member falsified weight as well as vital sign date for this resident .the investigation concludes that abuse, neglect, did occur. On 12/16/25 at approximately 11:35 a.m., R1 was observed sitting in the dining room waiting for the lunch meal service to begin. R1 appeared thin. When interviewed, R1 stated, I am tired in my head. I don't feel like eating. Review of R1's weights from 9/25/25 through 12/3/25 revealed the following weights:9/25/25 205.2 lbs; weight obtained by Certified Nurse Aide (CNA) D9/26/25 205.6 lbs; weight obtained by CNA A9/27/25 202.5 lbs; weight obtained by CNA E9/28/25 202.0 lbs; weight obtained by CNA E 10/1/25 202.2 lbs; weight obtained by CNA A10/8/25 202.4 lbs; weight obtained by CNA A10/15/25 201.6 lbs; weight obtained by CNA F10/29/25 202.1 lbs; weight obtained by CNA A11/5/25 202.3 lbs; weight obtained by CNA A11/12/25 202.0 lbs; weight obtained by CNA A11/19/25 201.7 lbs; weight obtained by CNA A11/26/25 201.9 lbs; weight obtained by CNA A12/1/25 178.2 lbs; weight obtained by Licensed Practical Nurse (LPN) G12/2/25 176.4 lbs; weight obtained by LPN [NAME] 12/17/25 at 10:05 a.m. an interview was conducted with R1's Designated Power of Attorney (DPOA) H who stated R1 was admitted in September at 205 pounds which was their usual body weight. R1 was started on Haldol (antipsychotic medication used to treat delirium behaviors) and that is when DPOA H noticed a change in R1's appetite and appearance. DPOA H stated they notified the facility around November 13th, 2025, with serious concerns and the facility responded, stating R1 had not lost any weight from admission. DPOA H stated they contacted the facility again near the end of November 2025, and the facility responded the resident had not lost any weight. DPOA H stated they began to get very frustrated with the facility when R1 was observed wearing sweatpants and a belt because of how much R1 had lost weight. DPOA H stated they are very upset at how the facility handled their concerns and felt the facility did not respond appropriately. An interview was conducted with the Director of Nursing (DON) on 12/17/25 at 10:24 a.m. The DON stated the facility reviewed video footage and confirmed CNA A did not consistently obtain weights and falsified documentation. CNA A was able to clearly describe how to obtain and document weights in her interview, she just didn't want to do it. On 12/17/25 at 10:46 a.m. a phone interview was attempted with CNA A. This Surveyor was unable to leave a voicemail as the mailbox was full, and CNA A did not return the call. Review of CNA A's 'Nurse Aide Skills Performance Checklist' dated 10/2/25 revealed a 'Vital Sign Skills' assessment which included 'Measure/record weight' with a 'Satisfactory' or 'Unsatisfactory' check mark. CNA A's vital sign skills assessment was left blank in the measure/record weight checklist. An interview was conducted with Registered Nurse (RN)/Education Director C on 12/17/25 at 11:32 a.m. RN C stated, when performing a CNA skills performance checklist, I don't tell them I am coming and only observe what they (CNA) are doing at the moment. I only check off what I see on the floor. An interview was conducted with Registered Nurse/Care Coordinator B on 12/17/25 at 11:57 a.m. RN B stated that a care conference was held on 12/17/25 at approximately 11:00 a.m. with the facility physician. RN B stated that the physician indicated that R1 would likely not regain the weight that was lost.Review of the facility's Freedom from Abuse, Neglect and Exploitation policy reviewed on 2/5/25 read, in part, It is the policy of [Facility Name] that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation .Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .