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	04/22/2026

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 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 and interview, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen.Findings Include:On 4/20/2026 at 11:42 AM observed Certified Nursing Assistant (CNA) P use a probe thermometer to take temperatures of a food item they were reheating in the microwave. The probe thermometer was observed to not have a protective sheath covering on it as it was being pulled from storage in the drawer. CNA P wiped the thermometer with an alcohol wipe prior to inserting it in the food product. Prior to placing the thermometer back into the drawer, CNA P wiped the thermometer again but did not place a protective sheath onto the cleaned thermometer prior to placing it in the drawer. On 4/20/2026 at 3:18 PM observed four plastic wine goblets being stored in the cabinet below the Courtyard ice machine. One of the goblets was observed directly touching the open drain line pipe where the ice machine drain line discharges into the floor drain. On 4/21/2026 10:25 AM the Certified Dietary Manager (CDM) Q stated that those goblets are not used for food service and that they were not sure why those would ever have been stored in that cabinet under the ice machine.According to the 2022 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLEUSE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. On 4/20/2026 at 12:11 PM observed the copper pipe drain line that comes from the Lemon Tree dining room ice machine discharging into a drain line in the employee kitchen downstairs. The end of the drain line was observed corroded for approximately 5 inches and the tip hanging above the drain was coated with black mildew and mineral build up. On 4/20/2026 at 3:18 PM observed the ice machine drain line in the Courtyard dining room indirectly connected to the floor drain by having the drain line inserted down into the floor drain pipe.According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. P

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents' rights to be free from verbal and mental abuse by a resident for two Residents (#4 & #62) of four residents reviewed for resident-to-resident abuse.Findings include:Resident #62 (R62)Review of the Electronic Medical Record (EMR) revealed R62 was originally admitted to the facility on [DATE], with diagnosis including generalized anxiety disorder, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. The Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 12/15, revealing that R62 had moderate impairments with thinking and memory.During an initial interview on 4/20/26 at 10:45 AM R62 stated residents had been wandering into her room. R62 stated recently Resident #9 (R9) had come into her room swearing and yelling at her to get out. R62 stated R9 had even called her names using swear words. R62 did not like R9 cursing at her or calling her names using swear words or that R9 was even in her room. R62 stated she felt nervous around R9, especially when R9 was wandering around the unit yelling at staff and residents. R62 felt no one on the unit was safe during R9's outburst episodes.Resident #4 (R4)Review of the EMR revealed R4 was admitted to the facility on [DATE] with diagnosis including chronic pain, major depressive disorder, and surgical amputation of left leg. The MDS indicated a BIMS score of 12/15 on 2/3/26, meaning R4 had moderate impairments with thinking and memory.During an initial interview on 4/20/26 at 11:21 AM, R4 stated R9 came into R4's room last week and stated, get the (expletive) out of my room. R4 indicated he asked R9 to leave the room as it was not R9's room but his. R9 then pushed R4's wheelchair across the room and raised his fist at R4 while swearing more, before leaving R4's room. R4 stated he is now uneasy around R9 and afraid of what R9 may do.R9Review of the EMR revealed R9 was admitted to the facility on [DATE] with diagnosis including vascular dementia unspecified severity with agitation, major depressive disorder, anxiety disorder, attention and concentration deficit and cognitive communication deficit. MDS indicated a BIMS score of 9/15, revealing R9 had moderate impairments with thinking and memory.On 4/20/26 at 11:36 AM, an interview was conducted with R9's Resident Representative (RR) S, who stated she was aware R9 had been going into other residents' rooms including the episode last week where he was yelling at other residents.Review of R9's EMR revealed the following progress notes:4/14/26 at 7:08 PM: Since nearly the start of shift, resident stated that if Satan was here, I would kill him.4/14/26 at 8:30 PM: Resident propelling self in w/c (wheelchair) past room. and stood in doorway with R62 standing in her room by her bed as R9 was in alcove of rooms yelling at R62 F**k you, f**k you, f**k you! and calling her (R62) a f**king b**ch as well as flipping her off because he wanted to use her bathroom. He told her he can use whatever bathroom he wanted around here because he owns the place.4/14/26 9:00 PM: Resident insisting he needed to go inside so he wanted to get out of bed. Once in w/c safely, he came into hallway where Certified Nursing Assistant (CNA) was assisting residents in rooms. He was continuing to invade other resident rooms, stating that he owned this place and was pushing past stop signs on doors, and opening doors that were closed trying to get into their rooms. He was adamant that nobody else had permission to live here because it was his house and that he needed to see the lease and their signatures of every person that had a room here.4/15/26 4:29 PM: Staff reported resident entering female room.kicking the door.4/16/26 8:05 AM: CC (Care Coordinator) was given a report by day nurse that resident had been a 1:1 (high-intensity intervention where a dedicated staff member continuously monitors a single patient) ed last night. Called the night nurse that worked the neighborhood to ask what happened. RN stated that resident was going from room to room screaming at other residents that they needed to leave his home because they were not paying the lease.4/16/26 9:58 PM: was yelling in hallway and pounding on the wall in room.4/17/28 9:20 PM: up going into others' rooms (females) drinking lots of coffee and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trying to get behind the nurses' station, watching nurses pass meds. Was given snacks.still wandered around the halls and went into others' roomsOn 4/21/26 at 11:41 AM R9 was observed sitting in his wheelchair raising his fist at random staff and residents as they passed by his room.On 4/22/2026 at 10:41 AM an interview was conducted with Social Worker (SW) T she stated she was aware of the incidents where R9 had gone into resident rooms and yelled at the residents. She stated she has not followed up with any of the residents regarding these incidents or how they felt about them. SW T had started saying I think it's because we are.tapering off the statement, then said I am not going to make excuses, I haven't done it.A follow up interview was conducted on 4/22/26 at 10:50 AM with R4 who stated R9 had banged on his closed door a few times, and R9 looks at R4 meanly and raises his fist to R4 when they pass in the hallway. R4 stated he is quite annoyed with R9's actions that keep R4 on his toes. R4 stated he is plenty capable of taking care of R9 but is trying not to utilize his former [NAME] arts or military training in order to make the tormenting from R9 go away.A phone interview was conducted with CNA O on 4/22/25 at 12:44 PM who stated she was working the night of 4/14/26 and was aware of R9's behaviors that night unfortunately. She stated R9 was more difficult to redirect than usual. CNA O stated staff had attempted interventions but R9 continued to yell at residents and go into rooms. She also stated she felt the resident across the hallway interacts with R9 in a manner that intensifies his behaviors when he starts to act out. CNA O stated they have told administration the men in that area should be separated to help control the issues with R9.Review of the facility's policy named Freedom from Abuse, Neglect and Exploitation last reviewed/revised on 1/28/26 indicated in part. each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subject to abuse by anyone, including, but not limited to: facility staff, other residents.Procedure.4. Verbal Abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.7. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.The Facility will:Not use verbal, mental, sexual or physical abuse, corporal punishment, exploitation, misappropriation of resident property, or involuntary seclusion.6. The facility will consider utilization of the following tips for prevention of abuse, neglect, and exploitation of residents:b. Observe resident behavior and their reaction to other residents, roommates, tablemates. Place residents in accommodations and environments that keep them calm. f. Take appropriate actions when abuse, neglect or exploitation is suspected. 7. Identification of Abuse, Neglect, and Exploitation e. Verbal abuse of a resident overheard.

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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 notify the State Agency (SA) of verbal and physical resident-to-resident altercations for three Residents (#4, #9, & #10) of four residents reviewed for abuse.Findings include: Resident #10 (R10) Review of R10's Electronic Medical Record (EMR) revealed initial admission to the facility on 3/26/25 with diagnoses including dementia with behavioral disturbance, delirium, restlessness and agitation, and psychotic disorder. Review of Section C: Cognitive Patterns in R10's most recent Minimum Data Set (MDS) assessment, dated 3/20/26, revealed her cognitive skills for daily decision making as, severely impaired-never/rarely made decisions. Further review of MDS Section E: Behaviors revealed R10 exhibited physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) and wandering that occurred between four to six days per week. On 4/20/2026 at 12:40 PM, the Nursing Home Administrator (NHA) was observed holding hands with R10 and walking up and down the hall. R10 was previously observed walking into the dining room during the lunch time meal where she reached out and contacted the back of a seated resident's head before redirection by staff. Review of R10's EMR revealed the following Physical Aggression Initiated reports in the previous three months: 2/8/26: [R10] walked into the Hydrangea Room and took cup from [resident name] who was sitting at one of the tables. [Resident name] told her it was her cup and they had a few words spoken in an angry tone. [R10] then threw her arm out and slapped [resident name] on the left side of her face with her open hand. 2/15/26: .[R10] entering [resident name's] personal space and when redirected, [R10] becoming agitated with staff member and calling that staff member an [expletive] and ended up taking her open hand and making contact to [resident name] in [sic] side of head. 2/18/26: [R10] was in dining room wandering when she approached [resident name], swatted her on the side of the head unprovoked. 3/3/26: [R10] observed ambulating on [hallway] near room [ROOM NUMBER]. [Resident name] walking past [R10]. [R10] taking open hand and making contact to [resident name's] shoulder. 4/2/26: CNA [Certified Nursing Assistant] informing this nurse that [R10] was in LR [living room] and picked up a rubber nerf ball, told a [resident name] to shut up and threw the ball in [resident name's] direction. Tbe [sic] ball did make contact with [resident name's] face. 4/3/26: [R10] was touching [resident name's] face, [resident name] swatted this [R10] away and said stop it then [R10] slapped [resident name] in the back of the head/neck. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/2026 at 12:32 PM, an interview was conducted with the Director of Nursing (DON) who verified she is part of the administration team, along with the NHA, who is made aware of all resident-to-resident interactions. The DON stated if incidents occur in common areas during off hours, security camera footage can be reviewed off facility premises. When asked why R10's previous six resident-to-resident incidents were not reported to the SA as instances of physical and/or verbal abuse, the DON stated it was because in each instance there was not an outcome, either mental or physical, or it could not be substantiated as abuse as determined by the administration team who reviewed the incident. Review of a witness statement written on 2/8/26 by CNA U surrounding the same dated incident read, in part: Describe events leading to incident/fall – [R10] can in + [and] randomly went + took [resident's] drink, which upset [resident]. [R10] gave it back but they had words w/ [with] each other + then [R10] smacked {resident] in the face. Your suggestions to prevent reoccurrence? I tried to calmly redirect [R10], but she wanted nothing to do with coming w/ me. She did walk w/ me after she slapped [resident]. I am not sure how to stop [R10] from randomly doing these things. Review of a witness statement written on 2/15/26 by CNA V surrounding the same dated incident read, in part: [R10] was aggressively reaching toward another resident. I touched her elbow in an effort to gently redirect. [R10] became agitated with me calling me an expletive and then proceeded to strike another resident on the right side of the head. Review of a witness statement written on 2/18/26 by CNA W surrounding the same dated incident read, in part: Describe events leading to incident/fall – [R10] walked up to another resident and cuffed them upside their head completely unprovoked. On 4/22/2026 at 11:53 AM, an interview was conducted with Licensed Practical Nurse (LPN) X who confirmed R10 had a long history of resident-to-resident interactions. LPN X stated, [R10] flips on a switch, there's no indication she will get physical. she can hit people in the side of the head for no reason. LPN X stated R10 has not caused any major injuries and although has advanced dementia and likely does not know what she is doing in most cases, she is intending harm during these resident-to-resident altercations. LPN X verified all resident-to-resident interactions are reported to administration as incidents of abuse. On 4/22/2026 at 12:22 PM, an interview was conducted with CNA Y regarding R10's behaviors. CNA Y stated there is no rhyme or reason for the outbursts and they largely remain unpredictable. CNA Y stated, [R10] can just walk up to somebody and cuff them in the back of the head. When asked the intentions of R10, CNA Y stated, It's not a love tap. she's trying to hurt them. Resident #9 (R9) Review of R9's EMR revealed initial admission to the facility on 9/4/24 with diagnoses including vascular dementia, unspecified severity with agitation, major depressive disorder, social exclusion and rejection, and attention and concentration deficit. Review of Section C: Cognitive Patterns in R9's (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	most recent Minimum Data Set (MDS) assessment, dated 3/11/26, revealed his cognitive skills for daily decision making as, moderately impaired thinking and memory. Further review of MDS Section E: Behaviors revealed R9 exhibited physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) resident rejected evaluation or care that is necessary to achieve the resident's goals for health and wellbeing, and wandering that occurred between one to three days per week. Review of R9's EMR revealed the following Physical Aggression Initiated report in the previous three months: 3/20/26 . It happened at nurse station on Valleyview A Hall area. This resident was using the resident I Pad at nurse station and it happened that R9 was there, I am not sure what triggered the incident because it was happening behind me. When this nurse turned notice both resident were hitting each other on their hands. When i asked R9 if he hit this resident he said yes. When this nurse attempted to prevent R9 from follow this female resident for more aggression, he hit this nurse in the back with his can (sic) Review of R9's EMR revealed he has had 47 Behavioral/Mood Note documented in the last three months, with behaviors including, verbal and physical aggression towards staff and residents. A Behavioral/Mood Note on 4/14/26 stated Resident propelling self in w/c past rooms , and stood in doorway with resident . standing in her room by her bed as resident was in alcove of rooms yelling at her, (expletive) you, (expletive) you, (expletive) you! and calling her a (expletive, expletive) as well as flipping her off because he wanted to use her bathroom. He told her he can use whatever bathroom he wanted around here because he owns the place. On 4/16/26 a Nursing Note stated .report by day nurse that resident had been a 1:1 (a staff member continuously monitors a high-risk patient) last night. Called the night nurse that worked the neighborhood to ask what happened. RN stated that resident was going from room to room screaming at other residents that they needed to leave his home because they were not paying the lease. On 4/16/26 Resident #4 (R4) was verbally assaulted and physically threatened by R9. On 4/22/26 at 11:30 AM an interview was conducted with the DON, who stated she was not aware of the incidents on 4/14/26 through 4/16/26 as they were not documented in Risk Management. Therefore, she could not properly have investigated them or reported them. Review of the facility policy titled, Freedom from Abuse, Neglect and Exploitation, reviewed 1/28/26, read, in part: .Residents must not be subject to abuse by anyone, including, but not limited to: facility staff, other residents. Physical Abuse includes, but not limited to hitting, slapping, pinching and kicking. Verbal Abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility will: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation or resident property, are reported immediately, but (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not later than 2 hours after the allegation is made, if the events that 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 the State Survey Agency and adult protected services where state law provides for jurisdiction in long-term care facilities) in accordance with State law.

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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. Based on interview and record review, the facility failed to investigate resident-to-resident abuse for three Residents (#4, #9, & #62) of four residents reviewed for investigation of abuse.Findings include:During an initial interview on 4/20/26 at 10:45 AM Resident #62 (R62) stated residents had been wandering into her room. R62 stated recently Resident #9 (R9) had come into her room swearing and yelling at her to get out. R62 stated R9 had even called her a (expletive, expletive). R62 did not like that R9 had called her that or been in her room.While conducting an initial interview with Resident #4 (R4) on 4/20/26 at 11:21 AM, R4 stated R9 came into their room last week and stated, get the (expletive) out of my room. R4 indicated he asked R9 to leave the room as it was not R9's room but his. R9 then pushed R4's wheelchair across the room and raised his fist at R4 swearing at R4 some more, before R9 left the room. R4 stated he is now uneasy around R9 and afraid of what R9 may do.A review of R4's Electronic Medical Record (EMR) indicated a progress note on 4/14/26 that read Resident insisting he needed to go inside so he wanted to get up out of bed. Once in w/c (wheelchair) safely, he came into hallway where CNA (Certified Nursing Assistant) was assisting residents in rooms of 108. He was continuing to invade other resident rooms, stating that he owned this place, and was pushing past stop signs on doors, and opening doors that were closed trying to get into their rooms. He was adamant that nobody else had permission to live here because it was his house and that he needed to see the lease and their signatures of every person that had a room here. On 4/21/26 at 10:02 AM, the Director of Nursing (DON) was asked to provide all accidents and incidents for R4, R9, R62 for the past three months. When the paperwork for accidents and incidents was provided, the 4/16/26 date was not included. When asked if this was a complete list and all paperwork of the accident and incidents for R4, R9, and R62, the DON stated that it was.On 4/22/26 at 10:35 AM, and interview was conducted with Registered Nurse (RN) K regarding the process for resident-to-resident incidents. RN K stated that for any resident-to-resident incident in which a resident goes into another resident's room and yells at another resident, the nurse should complete a resident-to-resident risk assessment in the facility's risk management documentation to start an investigation.On 4/22/2026 10:46 AM, a request was made to the DON for risk management documentation for resident-to-resident incidents for R4 from 4/14/26 to 4/16/26. At approximately 11:30 AM, the DON stated there were none. The DON stated she had initiated risk management for verbal aggression at that time to begin the investigation process.Review of the facility's policy titled Freedom from Abuse, Neglect and Exploitation last revised/reviewed on 1/28/26 indicated in part. 8. Investigation of Alleged Abuse, Neglect and Exploitation. When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the Long-Term Care Ombudsman was notified of a resident's discharge from the facility and ensure pertinent medical records were sent to the receiving provider upon transfer for two Residents (#3 & #6) of two residents reviewed for discharge practices. Findings include: Resident #3 (R3)Review of the Electronic Medical Record (EMR) for R3 indicated a transfer to the emergency department occurred on 3/12/26. Review of the documentation provided to the Long-Term Care Ombudsman in March, indicated they were not notified of the resident's discharge from the facility.Further review of R3's EMR revealed the facility failed to ensure medical documentation was communicated to the receiving hospital.Resident #6 (R6)Review of the EMR for R6 indicated a transfer to the emergency department occurred on 1/1/26. Review of the documentation in R6's EMR revealed the facility did not send medical documentation to the receiving provider.On 4/21/26 at 4:20 PM, an interview was conducted with the Nursing Home Administrator (NHA) who confirmed R3 was omitted from the March transfer list sent to the Long Term Ombudsman.On 4/21/26 at 4:25 PM, an interview was conducted with the Director of Nursing (DON) who verified she could not show proper documentation was sent to the local hospital for R3 and R6 during their transfers out of the facility.Review of policy titled, Transfer and Discharge including Against Medical Advice, dated 8/6/25, read in part Policy: It is the policy of Grandvue Medical Care Facility (GMCF) to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered.7. Emergency Transfers/Discharges - initiated by GMCF for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).d. Complete and send with the resident (or provide as soon as practicable) a Transfer Form which documents:Resident status, including baseline and current mental, behavioral and functional status and recent vital signs;Current diagnosis, allergies and reasons for transfer/discharge;Contact information of the practitioner responsible for the care of the resident;Resident representative information including contact information;Current medications (including when last received), treatments, most recent relevant lab and/or radiological findings and recent immunizations;Special instructions or precautions for ongoing care to include precautions such as isolation or contact;Special risks such as risk for falls, elopement, bleeding or pressure injury and/or aspiration precautions;Comprehensive care plan goals, andAny other documentation, as applicable, to ensure a safe and effective transition of care. A copy of any Advance Directive, Durable Power of Attorney, DNR or Withholding or Withdrawing of Life-Sustaining Treatment forms should be sent with the resident.j. Social Work Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list.

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	04/22/2026

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

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to provide hospice documentation for one Resident (#8) of one resident reviewed for hospice care services. This deficient practice resulted in the potential for uncoordinated care between the provider and the hospice care service. Findings include: Review of R8's Electronic Medical Record (EMR) revealed admission to the facility on 7/17/25 with active diagnoses that included frontotemporal neurocognitive disorder (a progressive brain disorder that primarily affects the frontal and temporal lobes). R8 was unable to complete the 4/28/26 Brief Interview for Mental Status (BIMS) score on the Minimum Data Set (MDS) assessment but was noted to have severely impaired cognition. The MDS assessment also documented R8's participation in hospice care.Review of R8's Physician Orders read, in part, ADMIT to [Hospice Name] .Active 10/13/25. On 4/21/26 at approximately 11:33 AM, review of R8's EMR revealed a Hospice Care Plan created on 7/21/25. Review of the MISC (miscellaneous) tab in the EMR found no Hospice Health Aide visit notes pertaining to the care and services provided to R8 by the Hospice Agency during January 2026 through April 2026.Review of the [Hospice Agency] binder, located in the nursing room, for R8 revealed no further documentation of Hospice Health Aide visit notes from January 2026 through April 2026.During an interview on 4/22/26 at 10:28 AM, Licensed Practical Nurse (LPN) D was asked about the [Hospice Agency] care provided to R8. LPN D stated the hospice agency would sometimes communicate with the facility staff but was unable to tell this Surveyor where the documentation was located if it wasn't in R8's EMR or Hospice Binder. During an interview on 4/22/26 at 11:16 AM with Nursing Care Coordinator/Staff Z regarding R8's Hospice Health Aide documentation, Staff Z stated they have not been given any documentation from that Hospice Agency in quite some time.During an interview with the Director of Nursing (DON) on 4/22/26 at 12:00 PM regarding R8's hospice documentation, the DON confirmed it was missing from R8's EMR.Review of the Hospice Care policy, provided on 4/1/26 at approximately 11:30 a.m., revealed the following, in part: .The facility will initiate and maintain a medical record on each hospice resident. Hospice staff will document progress information on hospice forms, leaving a copy of such notes with the facility. The facility will retain these notes as a part of the resident's permanent record .Review of the Services Agreement Contract with [Hospice Agency Name] and [Facility Name] read, in part, .Facility and Hospice shall each designate in writing a representative to communicate with each other.to ensure that the needs of Hospice patients are addressed and met twenty-four hours a day. The Hospice and Facility representatives shall document and keep written records of all such communications and shall document that the services provided are furnished in accordance with the terms of this Agreement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to store respiratory equipment in a sanitary manner for two Residents (#35 & #47) of two residents reviewed for respiratory care.Findings include:Resident #35 (R35)On 4/20/26 at 11:21 AM, an observation was made of R35's nebulizer mask intact (put together) and sitting on the nightstand not stored in a bag. R35 was asked when the last time he used his nebulizer mask to which he replied, I used it yesterday. R35's nebulizer medication cup was noted to have some condensation remaining inside.During an observation on 4/21/26 at 10:15 AM, R35's nebulizer mask was sitting on their nightstand intact, open to air and not stored in a bag. On 4/22/26 at 10:04 AM, R35's nebulizer mask was observed intact and sitting on his night stand not stored properly in a bag.Resident #47 (R47)On 4/20/26 at 11:04 AM, an observation was made of R47's room. R47 was absent from her room, and her nasal cannula tubing was observed lying on the floor. The floor where the nasal cannula was lying had visible dirt and crumbs. R47's nebulizer mask was observed intact and not stored in a bag.R47's nebulizer mask on 4/22/26 at 9:05 AM, was observed intact and not stored properly in a bag. R47's oxygen concentrator was running, and her nasal cannula was lying on the floor.On 4/22/26 at 9:15 AM, an interview was conducted with Registered Nurse (RN) G / Infection Preventionist regarding the storage for respiratory equipment. RN G stated, Respiratory equipment should be stored in a bag when not in use and nebulizer masks are to be rinsed and dried after use.On 4/22/26 at 9:25 AM, an interview was conducted with RN C who was asked about respiratory equipment storage and replied, It is to be stored in a bag when not in use and if the nasal cannula is on the floor that should be thrown away.Review of policy titled, Oxygen, Administration of, dated 8/6/25, read in part, Policy: It is the policy of Grandvue Medical Care Facility (GMCF) that supplemental oxygen will be provided for residents by order of a physician.Procedure.Bags for storage of nasal cannula when not in use.