STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235067	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Shiawassee County Medical Care Facil	275 Caledonia Drive Owosso, MI 48867

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to complete resident treatments per physician order for seven residents (R4, R5, R7, R8, R9, R10, R11) of eight residents reviewed. Findings include:A review of the facilities Facility Reported Incident (FRI) investigation summary revealed that on [DATE], Certified Nursing Assistant (CNA) D and RN E recognized that RN F was being inattentive to her assigned resident's needs. She was observed spending time on her personal cellphone with prolonged periods of sitting in the nurses station and had not completed a dressing for a resident but charted she had done so. These concerns were reported to the on-call manager, RN G on [DATE] at 6 PM. RN F was interviewed and reported that she believed she had completed the dressing. RN F was sent home after a second resident was found to not have their treatment done but it had been charted as completed. During the assessment and interview of residents assigned to RN F both R4 and R5 reported their treatments for day shift had not been completed. R4 was interviewed by RN E and stated that her treatment had not been completed, RN E assessed the wicking sheets that had been placed in R4's neck folds, chin, shoulder and chest. The wicking sheets were observed to have an odor and did not appear to have been recently changed. RN E asked RN F about it and she reported I thought that I did it, I must have clicked it by mistake. This treatment was charted on [DATE] at 2:02 PM by RN F. R5 was interviewed by RN E on [DATE] and reported that she did not receive her creams for her back and the antifungal powder for under her breasts. Documentation was reviewed and RN F had charted the treatments as being completed on [DATE] at 2:03 PM. Based on interviews and assessments on [DATE], the facility believed that all treatments except for R4 and R5's had been completed. Their investigation continued and included a camera review for RN Fs shift. During the camera review RN Fs shift, it was identified that she spent approximately 50% of her time seated at the nurses station while very intermittently accessing the vital signs binder and computer. The remainder of time she was sitting and or on her personal cellphone in the nurse's station. It was during the camera review that it was observed that RN F did not complete every treatment on [DATE] because she did not enter the room of every resident who had a treatment ordered. This concern was immediately reported to the administrator on [DATE] and reported to the State Agency on [DATE]. The facilities FRI investigation did not include information related to any additional residents (besides R4 and R5) that had been identified as not receiving their treatments from RN F on [DATE]. On [DATE] at 11:48 AM, during an interview with Director of Nursing (DON), when asked if their investigation had revealed additional residents that had not received their treatments from RN F on [DATE], she confirmed additional residents were identified and that the facility completed an incident report for each of them. On [DATE] at 12:21 PM, DON provided incident reports for 5 additional residents that did not receive treatments on [DATE] during RN Fs shift.A review of incident reports provided by DON revealed: an incident report dated [DATE] for R7 Nurse (RNF) failed to complete ordered treatments on [DATE] day shift. Treatments: Caldesene External Powder 81-15%, Apply to abdominal folds topically one time a day for protection.Monitor LLE (left lower extremity) stump for S/S (signs and symptoms) of breakdown.Clean right inner ankle with normal saline, dry and apply 1x3 band-aid., an incident dated [DATE] for R8 Nurse (RN F) failed to complete (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment orders on [DATE] for day shift. Treatments not completed: Hydrogen peroxide external gel 1.8%, Apply to forearms topically two times a day for sunburn for 3 weeks, an incident report dated [DATE] for R9 Nurse (RNF) failed to complete ordered treatments on [DATE] for day shift. Treatments: Clean tip of right pinky with normal saline, dry and cover with 1x3 band-aid. Discontinue when healed. Wound treatment: Right heel-Apply betadine, cover with Aquacel, secure with Conva-foam patch daily to right heel., an incident report dated [DATE] for R10 [DATE] 1100 to 1930 shift Nurse (RN F) failed to do resident's treatments: Cleansing of anterior and posterior cervical incision sites, and wound treatments on right glute/right gluteal cleft, an incident reported dated [DATE] for R11 (RN F) failed to complete treatments on [DATE] for day shift.R4A review of the medical record revealed R4 was admitted to the facility on [DATE], deceased on [DATE] and according to the Minimum Data Set (MDS) assessment dated [DATE], R4 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).R5On [DATE] at 1:19 PM, R5 was observed lying in bed. R5 reported that outside of the missed treatment, staff complete her prescribed treatments when they can and that they (staff) are pretty busy. She denied any complications from missed treatments. A review of the medical record revealed R5 was admitted to the facility on [DATE] and according to the Minimum Data Set (MDS) assessment dated [DATE], R5 scored 14/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).R7On [DATE] at 3:30 PM, R7 was observed self-propelling in a manual wheelchair. During interview R7 reported he did not have any concerns with receiving prescribed treatments outside of the missed treatment. A review of the medical record revealed R7 was admitted to the facility on [DATE] and according to the Minimum Data Set (MDS) assessment dated [DATE], R5 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).R8On [DATE] at 3:34 PM, R8 was observed sitting up in a recliner. During interview R8 denied any overall concerns with receiving prescribed treatments besides a recently missed treatment. A review of the medical record revealed R8 was admitted to the facility on [DATE] and according to the Minimum Data Set (MDS) assessment dated [DATE], R8 scored 12/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition).R9A review of the medical record revealed R9 was admitted to the facility on [DATE] and discharged on [DATE] and according to the Minimum Data Set (MDS) assessment dated [DATE], R9 scored 10/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition).R10On [DATE] at 3:25 PM, R10 was observed sitting up at the edge of her bed. During interview R10 conveyed they had a missed treatment and denied any concerns with regularly receiving prescribed treatments. She added that she had 2 surgeries on her neck and she had been advised that the surgical sites look good. A review of the medical record revealed R10 was admitted to the facility on [DATE] and according to the Minimum Data Set (MDS) assessment dated [DATE], R9 scored 14/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).R11A review of the medical record revealed R11 was admitted to the facility on [DATE] and according to the Minimum Data Set (MDS) assessment dated [DATE], R11 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). Seven residents were identified as not receiving treatments on [DATE] while under the care of RN F.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure accurate medical records for seven residents (R4, R5, R7, R8, R9, R10, R11) of eight residents reviewed. Findings include:A review of the facilities Facility Reported Incident (FRI) investigation summary revealed that on 5/16/26, Certified Nursing Assistant (CNA) D and RN E recognized that RN F was being inattentive to her assigned resident's needs. She was observed spending time on her personal cellphone with prolonged periods of sitting in the nurses station and had not completed a dressing for a resident but charted she had done so. These concerns were reported to the on-call manager, RN G on 5/16/26 at 6 PM. RN F was interviewed and reported that she believed she had completed the dressing. RN F was sent home after a second resident was found to not have their treatment done but it had been charted as completed. During the assessment and interview of residents assigned to RN F both R4 and R5 reported their treatments for day shift had not been completed. R4 was interviewed by RN E and stated that her treatment had not been completed, RN E assessed the wicking sheets that had been placed in R4's neck folds, chin, shoulder and chest. The wicking sheets were observed to have an odor and did not appear to have been recently changed. RN E asked RN F about it and she reported I thought that I did it, I must have clicked it by mistake. This treatment was charted on 5/16/26 at 2:02 PM by RN F. R5 was interviewed by RN E on 5/16/26 and reported that she did not receive her creams for her back and the antifungal powder for under her breasts. Documentation was reviewed and RN F had charted the treatments as being completed on 5/16/26 at 2:03 PM. Based on interviews and assessments on 5/16/26, the facility believed that all treatments except for R4 and R5's had been completed. Their investigation continued and included a camera review for RN Fs shift. During the camera review RN Fs shift, it was identified that she spent approximately 50% of her time seated at the nurses station while very intermittently accessing the vital signs binder and computer. The remainder of time she was sitting and or on her personal cellphone in the nurses station. It was during the camera review that it was observed that RN F did not complete every treatment on 5/16/26 because she did not enter the room of every resident who had a treatment ordered. This concern was immediately reported to the administrator on 5/21/26 and reported to the State Agency on 5/21/26.The facilities FRI investigation did not include information related to any additional residents (besides R4 and R5) that had been identified as not receiving their treatments from RN F on 5/16/26.On 7/2/2026 at 11:48 AM, during an interview with Director of Nursing (DON), when asked if their investigation had revealed additional residents that had not received their treatments from RN F on 5/16/26, the DON confirmed additional residents were identified and that the facility completed an incident report for each of them.On 7/2/26 at 12:21 PM, DON provided incident reports for 5 additional residents that did not receive treatments on 5/16/26 during RN Fs shift.A review of incident reports provided by DON revealed: an incident report dated 5/22/26 for R7 Nurse (RNF) failed to complete ordered treatments on 5/16/26 day shift. Treatments: Caldesene External Powder 81-15%, Apply to abdominal folds topically one time a day for protection.Monitor LLE (left lower extremity) stump for S/S (signs and symptoms) of breakdown.Clean right inner ankle with normal saline, dry and apply 1x3 band-aid., an incident dated 5/22/26 for R8 Nurse (RN F) failed to complete treatment orders on 5/16/26 for day shift. Treatments not completed: Hydrogen peroxide external gel 1.8%, Apply to forearms topically two times a day for sunburn for 3 weeks, an incident report dated 5/22/26 for R9 Nurse (RNF) failed to complete ordered treatments on 5/16/26 for day shift. Treatments: Clean tip of right pinky with normal saline, dry and cover with 1x3 band-aid. Discontinue when healed. Wound treatment: Right heel-Apply betadine, cover with Aquacel, secure with Conva-foam patch daily to right heel., an incident report dated 5/22/26 for R10 5/16/26 1100 to 1930 shift Nurse (RN F) failed to do resident's treatments: Cleansing of anterior and posterior cervical incision sites, and wound treatments on right glute/right gluteal cleft, an incident reported dated 5/22/26 for R11 (RN F) failed (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to complete treatments on 5/16/26 for day shift.Seven residents were identified as not receiving treatments on 5/16/26 while under the care of RN F, however RN F documented the treatments as being completed in the residents electronic medical record.On 7/2/26 at 2:11 PM, during an interview with DON, it was confirmed that RN F had not completed treatments for R4, R5, R7, R8, R9, R10 and R11 but had documented them as completed in the electronic medical record for each resident.On 7/2/26 at 3:55 PM DON reported that the expectation for documenting treatments is for them to be done in real time, once completed and accurately. DON reported that the facility provides frequent education on appropriate documentation.Record reviews for R4, R5, R7, R8, R9, R10 and R11 revealed on 5/16/26 RN F had documented on the Medication Administration Record that the prescribed treatments had been completed.A review of the facilities policy titled Charting/Documentation documented in part General guidelines.Be concise, accurate, complete and use objective terms.Document only the facts.