STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235076	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newaygo CO Medical Care Facility	4465 West 48th Street Fremont, MI 49412

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident or the resident's responsible party in writing of the reason for hospital transfers and/or the facility's bed hold policy for 2 of 3 residents (R43 and R58) reviewed for hospitalizations. Findings include: Resident #43 (R43) Review of R43's Electronic Medical Record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and congestive heart failure (CHF). Review of R43's MDS assessment, dated 5/13/26, revealed a BIMS score of 11, indicative of moderate cognitive impairment. Further review of the EMR revealed R43 appointed a medical Durable Power of Attorney (DPOA), effective 9/5/25. During an interview on 6/01/2026 at 11:38 AM, R43 confirmed several recent hospitalizations. R43 was unable to answer questions related to bed hold or transfer notifications. Review of a facility census report revealed R43 was hospitalized from [DATE]-[DATE], 3/19/26-3/21/26, 1/20/26-1/25/26, and 1/14/26-1/18/26. A review of R43's EMR did not reveal any documentation which indicated R43 or their medical DPOA were notified in writing of the reason for the hospital transfer or bed hold policy for any of R43's previous four hospitalizations. On 6/02/2026 at 11:24 AM, an interview was conducted with the DON who confirmed the facility did not send a transfer notification to R43's medical DPOA for any hospitalization and indicated it was a facility process failure. The DON stated the bed hold notice was sent with R43 during each transfer to the hospital and not retained in the EMR. Review of the facility policy titled, [Facility Name] Bed Hold, revised 1/28/26, read, in part: .the facility will have a process in place to ensure residents and/or their representatives are made aware of the facility's bed-hold and reserve bed payment policy well in advance of being transferred to the hospital. the facility will provide written information about these policies to residents and/or resident representatives prior to and upon transfer. a signed and dated copy of the bed-hold notice information will be kept in the resident's admission file. On 6/03/2026 at 8:45 AM, an interview was conducted with the Nursing Home Administrator (NHA) who stated the facility was in the process of creating a Transfer Notification policy. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235076	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newaygo CO Medical Care Facility	4465 West 48th Street Fremont, MI 49412

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R58 A review of R58's admission Record, dated 6/2/26, revealed R58 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included anemia and weakness. In addition, the admission Record revealed R58 was their own responsible party, and their spouse was their first emergency contact in the event they were unable to make decisions in an emergent situation. A review of R58's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/25/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 14 which revealed R58 was cognitively intact. A review of R58's Health Status Note, dated 3/25/25, revealed R58 was concerned because she had blood in her brief and was unable to have a bowel movement. The physician/health care provider was notified and requested R58 be transferred to the emergency room for an evaluation and treatment. R58's spouse was called and R58 was sent via ambulance to the emergency room at 1:10 AM. A review of R58's electronic medical record, dated 3/18/26 to 6/2/26, failed to reveal any documentation that R58 and/or their spouse was notified in writing of the reason for the hospital transfer on 3/25/26. In addition, a review of R58's electronic medical record failed to reveal any documentation that R58 and/or their spouse was notified of the facility's bed hold policy (in writing or verbally) at the time of R58's transfer to the hospital on 3/25/26 or soon thereafter. During an interview on 6/2/26 at 1:30 PM, the Director of Nursing (DON) stated they call the resident's family/responsible party to notify them when the resident is transferred to the hospital and verbally tell them the reason for the transfer. The DON stated that she thought that was good enough for the notification and she was not aware that the facility had to give them something in writing. During a second interview on 06/02/2026 at 2:00 PM, the DON stated she knew that the facility was supposed to give residents the bed hold policy every time they go to the hospital. She stated that she can see that they did not give R58 and/or her spouse the bed hold policy in writing when they sent her to the hospital. The DON also verified that the copy of the bed hold policy form that was sent with R58 to the hospital on 3/25/26 was blank (indicating that the bed hold policy was not addressed with R58 and/or their spouse).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235076	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newaygo CO Medical Care Facility	4465 West 48th Street Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update and implement care plan interventions for 2 residents (R2 and R6) of 3 residents reviewed for accidents and falls. Findings: R2Review of an admission Record revealed R2 initially admitted to the facility on [DATE] with pertinent diagnoses which included Parkinson's disease, dementia, delusional disorders, and hallucinations. Review of a current risk for falls Care Plan intervention for R2, initiated 12/12/2024, directed staff that R2 required a DPM mattress (a specialized mattress with edges or bolsters) to help define edges of R2's bed. Upon further review of R2's risk for falls Care Plan intervention initiated on 3/15/2021, it directed staff that R2 had a sign on his walker to remind him to use the walker when he ambulated. In an observation and interview on 6/2/2026 at 12:24 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) D reported that R2's interventions that included the DPM mattress and the sign to remind R2 to use his walker were no longer in his room and had been discontinued. LPN/UM D reported she could not recall when those interventions were removed and that R2 no longer used his walker although his walker remained in his room. LPN/UM D reported that she was not sure how updating the fall risk Care Plan was missed. LPN/UM D reported that when R2's fall risk Care Plan is updated, the updated version is placed into R2's closet. In an interview on 6/2/2026 at 12:46 PM, Certified Nursing Assistant (CNA) E was queried how he would receive communication regarding change of fall interventions and he reported he would look at the Care Plan in the closet. R6Review of an admission Record revealed R6 initially admitted to the facility on [DATE] with pertinent diagnoses which included cerebrovascular disease (condition affecting blood flow), dementia, and hypertension. Review of a current risk for fall's Care Plan' intervention for R6, initiated 5/30/2026, directed staff that R6 required a urinary leg bag when up in his wheelchair as R6 would allow. In an observation and interview on 6/2/2026 at 12:24 PM, LPN/UM D reported that R6 had attempted to ambulate from his wheelchair on 5/30/2026 and tripped over his urinary catheter tubing and the intervention for that occurrence had been to direct staff that R6 required a urinary leg bag when he was in his wheelchair as he would tolerate. In an observation and interview on 6/2/2026 at 12:46 PM, R6 was seated in his wheelchair at the table with a catheter bag underneath his wheelchair in a privacy bag. CNA E reported he was not aware that R6's recent fall and intervention for that fall was to attach a urinary leg bag so R6 would not trip over his urinary catheter tubing. CNA E was queried how he would receive communication regarding change of fall interventions for R6 he reported he would look at the Care Plan in the closet. CNA E reported he had not reviewed R6's plan of care prior to assisting him from his bed to the dining room. In an interview on 6/3/2026 at 10:05 AM, the Director of Nursing (DON) reported that the risk for falls Care Plan should have been updated with any new or discontinued interventions to prevent further falls from occurring. DON reported that facility staff are expected to review plans of care prior to assisting residents. Review of facility policy/procedure Fall Prevention Program, reviewed 1/9/2026, revealed .When any resident experiences a fall, the facility will review the resident's care plan and update as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235076	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newaygo CO Medical Care Facility	4465 West 48th Street Fremont, MI 49412

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to initiate and/or properly follow bowel protocol for one Resident (#8) out of one resident reviewed for bowel and bladder management.Findings include:Resident #8 (R8)Review of R8's Electronic Medical Record (EMR) revealed initial admission to the facility on 3/6/26 with diagnoses including vascular dementia, congestive heart failure (CHF) and anxiety disorder. Review of R8's Minimum Data Set (MDS) assessment, dated 3/12/26, revealed a Brief Interview for Mental Status (BIMS) score of 6, indicative of severe cognitive impairment.Review of R8's EMR revealed the following progress notes:4/16/26 at 2:53 PM: .Patient does seem to have a large amount of hard stool in her rectum, but she states she's unable to pass it.4/30/26 at 1:37 PM: .[R8] also stated she felt like I gotta [sic] go to the bathroom but it won't come. She passed a small amount of hard stool but more stool is visable [sic] in her rectal vault.5/1/26 at 12:56 PM: residen[t] without reported BM [bowel movement] x5 days.5/5/26 at 3:47 PM: .[R8] complained of feeling like she needs to go but it won't come out. Stool is present in anus, but she is unable to push it out.5/6/26 at 11:16 AM: .Pt [patient] also with no BM documented since 5/2/[26].5/8/26 at 12:21 PM: .[R8] tolerated shower okay, but did complain of needing to pass stool but unable to and also lower back pain.5/15/26 at 1:25 PM: Shower provided for [R8]. She complained of constipation and right side back pain.5/28/26 at 11:18 AM: .Noted, no BM charted since 5/23/[26]. Abdomen is distended and firm, but non-tender.On 6/03/2026 at 7:58 AM, R8 was observed lying in bed eating breakfast. R8 was unable to answer questions related to her bowel regimen. On 6/03/2026 at 9:37 AM, an interview was conducted with Certified Nursing Assistant (CNA) L regarding R8's bowel regimen. CNA L stated R8 tends to have firm, hard stools.Review of R8's bowel elimination record during a lookback period from 5/4/26 - 6/2/26 revealed the following:No bowel movement from 5/4/26 to 5/8/26 at 10:27 PM (over 4 elapsed days).No bowel movement from 5/9/26 at 10:36 AM to 5/17/26 at 6:12 AM (over 7 elapsed days).No bowel movement from 5/17/26 at 6:12 AM to 5/23/26 at 2:45 PM (over 6 elapsed days).No bowel movement from 5/23/26 at 2:45 PM to 5/30/26 at 6:08 PM (over 7 elapsed days).Review of R8's plan of care revealed a focus, initiated 3/6/26, which read, I am at risk for altered elimination of bowel and/or bladder related to limited mobility. R8's plan of care revealed a goal which stated, I will have a normal bowel movement at least every third day. with the following interventions: Follow facility bowel protocol. Provide bowel medication as ordered by physician.On 6/02/2026 at 2:04 PM, an interview was conducted with Licensed Practical Nurse/Unit Manager (LPN/UM) D regarding the facility's bowel protocol. LPN/UM D stated each evening nurse should run a bowel report at the end of their shift and hand it off to their oncoming dayshift replacement. LPN/UM D indicated if a resident does not have a bowel movement for three days, milk of magnesia is administered at noon on the third day. LPN/UM D stated if the resident does not have bowel movement by evening of the third day, a suppository would then been administered. Should the suppository not be effective, LPN/UM D indicated a phosphate enema would then be administered on the following 11:00 PM - 7:00 AM shift.Review of R8's physician orders revealed the following active orders:Milk of Magnesia Suspension 1200 MG [milligrams]/15ML [milliliters]. give 30 ml po [by mouth] at noon for no BM in 3 days, initiated 3/6/26. Dulcolax Suppository (Bisacodyl) Insert 1 suppository rectally as needed for No BM in 3 days, give at hs [at night], initiated 3/6/36.Phosphate Enema 7-19 GM/118ML, give 1 enema rectally on 11-7 shift for no BM in 3 days, initiated 3/6/26.Review of R8's Medication Administration Record (MAR) revealed from 5/4/26 - 6/2/26, the following bowel medications were administered:Milk of Magnesia Suspension: 5/4/26 at 4:24 PM (effectiveness was unknown), 5/23/26 at 8:54 AM (ineffective).Dulcolax Suppository: 5/29/26 at 11:49 AM (ineffective).Phosphate Enema: 5/30/26 at 12:17 PM (effective).On 6/03/2026 at 8:45 AM, an interview was conducted with the Director of Nursing (DON) who validated concerns regarding noncompliance with R8's bowel protocol including failure to initiate the protocol (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235076	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newaygo CO Medical Care Facility	4465 West 48th Street Fremont, MI 49412

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timely and failing to follow the protocol per facility policy.Review of the facility policy titled, Bowel Management Program, revised 5/4/26, read, in part: .Step 1: At noon the Resident will be given Milk of Magnesia (MOM) as ordered or have a physician's order to hold the medication. The nurse will document the medication in the Residents EMR.Prior to the end of the Day Shift nurse reporting off to the next shift, She will review if the Milk of Magnesia was effective and document the results in [EMR] for the follow up prn [as needed] charting. If the Resident has not had a BM the nurse will report to the next shift nurse. 5. Step 2: Completed at HS: Evening shift nurse will review all Residents who were given Milk of Magnesia without results and proceed to second step of Bowel Protocol. A Dulcolax suppository will be given and documented in the Resident's EMR, unless a physician's order has been obtained to hold the medication. 6. The evening shift nurse will review the results of the Dulcolax suppository. If the suppository is ineffective, the nurse will document the results in the EMR and initiate step 3 of the bowel protocol. 7. Step 3 of Bowel Protocol: Completed prior to resident rising in the am: If the resident does not have a BM recorded after receiving Step II and Step 2 of the bowel protocol, a Fleets enema will be given per Resident's orders, unless a physician's order has been obtained to hold the medication. 8. The Night shift nurse will record the results of the Fleets enema in the Resident's EMR- If there is no BM after the Fleets enema, Physician notification is required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235076	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newaygo CO Medical Care Facility	4465 West 48th Street Fremont, MI 49412

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently implement standards of practice and follow policy and procedures for narcotic reconciliation for 1 of 6 medication carts. Findings:On 06/02/26 at 7:05 AM, a review of the narcotic book for the medication cart on Sunflower unit revealed a Fentanyl Patch Proof of Use Form for the resident in room [ROOM NUMBER]-1. The entries dated 05/22/26 at 10:04 AM and 05/31/26 at 1:00 PM only had one nurses signature. On 06/02/26 at at 8:15 AM, a review of the same narcotic book on the Sunflower unit and the Fentanyl Patch Proof of Use Form for the resident in room [ROOM NUMBER]-1 revealed that the entry dated 05/31/26 at 1:00 PM now had two nurses signatures on it. During an interview on 06/02/25 at 8:25 AM, Registered Nurse (RN) B stated that she had signed the Fentanyl Patch Proof of Use Form this morning for the resident residing in room [ROOM NUMBER]-1 and for the entry made on 05/31/26, without witnessing the destruction of the Fentanyl patch on 05/31/26. During an interview on 06/02/26 at 8:34 AM, Licensed Practical Nurse (LPN) C indicated that signing a proof of use form for the destruction of a Fentanyl patch without witnessing the destruction of the patch was not a standard of practice and was something that she would never do. Review of the facility policy and procedure Narcotic Pain Patch reflected .the used (fentanyl) patch will be disposed of by the nurse removing the patch and another nurse verifying the destruction of the patch.