| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235157 | A. Building<br>B. Wing | 02/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sanilac Medical Care Facility | 137 North Elk Street<br>Sandusky, MI 48471 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Past Non-Compliance (PNC) was identified during the investigation of the deficient practice and was accepted by the survey team upon exit from the facility for this citation. Following discussion with the State Manager, Past Non-Compliance was accepted with a Compliance Date of 01/28/2026.Based on observation, interview and record review, the facility failed to ensure resident safety when care-planned interventions were not followed during a transfer to a wheelchair for one resident (Resident #1) of four residents reviewed for an injury of unknown origin. Findings include:Resident #1 (R1):On 2/2/26 at 12:29 PM, an observation was made of Resident 1 (R1) sitting in their wheelchair in the dining area of the secured unit of the facility. The Resident had her right leg elevated with a cast on it. The Resident had drinks in front of her and the residents in the dining area were getting ready to eat. An observation was made of a sling with red trim positioned underneath the Resident. The sling was a mechanical lift sling for use with a mechanical lift when transferring the Resident. An observation was made of a mechanical lift positioned in the hallway of the unit.A review of R1's medical record revealed an admission into the facility on 6/17/16 with a readmission on [DATE] with diagnoses that included Alzheimer's disease, muscle wasting and atrophy, muscle weakness, need for assistance with personal care and fracture of right tibia. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 00/15 that indicated severely impaired cognition, and the Resident was dependent on a helper for transfers, bathing, dressing and personal hygiene.A review of the facility reported incident revealed that on 1/8/26 at approximately 8:30 AM, staff notified the Director of Nursing that the resident was complaining of pain to the right lower extremity with deformity noted. The origin of the injury is unknown at this time. No fall, accident, or injury was witnessed or reported. The resident was under routine care and supervision at the time the injury was identified. Diagnostic imaging completed at (hospital) at approximately 9:15 AM revealed: Acute comminuted mildly displaced fracture of the distal tibial metadiaphysis Acute mildly displaced fracture of the distal tibial diaphysis. Due to the results of the x-Ray, the residents transferring status was changed from Assist of One (1) using the Hoyer Lift with a Red Trim Sling to Assist of Two (2) using the Hoyer Lift with a Red Trim Sling.A review of staff interviews during the investigation revealed, (CNA H) was scheduled to work on the 700 Hall on 1/7/26-1/8/26 from 10:00 PM (to) 6?00 AM. During the conduction of the interview, CNA ( H) reported assisting resident (R1) into own personal wheelchair prior to 6:00 AM on 1/8/26 with CNA ( H) reporting that a two (2) person assist was utilized; the resident's transferring status was Assist of One (1) using the Hoyer Lift with a Red Trim Sling per plan of care at this time. CNA ( H) was unable to recall who assisted with said transfer. Per CNA ( H) resident (R1) did not complain of pain following the completion of this transfer, and no accident or injuries occurred during this time. There was clear deviation from the residents individualized plan of care as a manual transfer was utilized in lieu of utilizing the required mechanical lift; the residents<br><br>(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: 235157 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/02/2026 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Sanilac Medical Care Facility | | STREET ADDRESS, CITY, STATE, ZIP CODE 137 North Elk Street Sandusky, MI 48471 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | individualized plan of care was clear, and CNA ( H) was trained appropriately.Review of staff interviews revealed the evening on 1/7/26, R1 was transferred by a CNA and Nurse back to bed, the sling used had been soiled and was placed in the laundry.On 2/2/26 at 12:07 PM, an interview was conducted with the Director of Nursing (DON). The incident with injury of unknown origin of a fracture of R1's leg and investigation completed was reviewed with the DON. The DON indicated that they identified that the CNA had not followed the plan of care when transferring the resident into her wheelchair prior to the discovery of the injury. The DON revealed that she had reached out to the CNA after it was identified that he had not followed the plan of care, but the CNA had not called her back, and the facility had terminated employment of CNA H. The DON reported that all Residents had their plan of care reviewed and ensured that residents were being transferred safely and per the plan of care. Education was provided to Nurses and CNAs, all assigned staff had completed the education, and they were monitoring to make sure care plans were followed during transfers. The DON indicated that they were in compliance. On 2/2/26 at 12:25 PM, an interview was conducted with Laundry Staff A regarding laundering and availability of mechanical lift slings. The staff reported that a dirty sling would be brought down to the laundry if dirty and if brought down at night, would be cleaned in the morning of the next day. The Staff reported that there were extras of each color of slings available in the laundry department where the slings are stored and that the trim color needed goes by the weight of the Resident. The Laundry Staff stated, There is plenty of each color available in the laundry. On 2/2/26 at 12:52 PM, interviews were conducted with CNA B, CNA C, and Unit Clerk/CNA D regarding the available mechanical lifts. An observation was made of a mechanical lift in the hallway of the 300 hall and 500 Hall. The CNAs were asked if there were enough mechanical lifts available to meet the needs of the residents. The three CNAs responded that there was not an issue with a lift not being available and what they had available was plenty to meet the residents' needs. The CNAs reported recent abuse education and following plan of care for residents. All three CNAs indicated they had completed the education. When asked about the availability of slings, the CNAs reported that if they were not available in the room for the resident, they could get one from laundry that was not far to go and was open all the time including off hours. The CNAs reported they did not have concerns of slings not being available and that there was enough of the needed trim color available to meet resident needs. On 2/2/26 at 2:20 PM, an interview was conducted with Assistant Director of Nursing (ADON) F. The ADON reported that he had oversight of staff education and that mandatory education on abuse training and following the plan of care education was made mandatory for Nurses and CNAs with a completion date by 1/22/26. A review of education revealed some staff had not completed the training by 1/22/26 with staff completion by 1/28/26. On 2/2/26 at 2:47 PM, an interview was conducted with CNA I regarding availability of mechanical lift in the 700 Hall. The CNA reported that the lift was always available and that the one on the unit was enough to meet the needs of the Resident. The CNA reported that the CNA was responsible for looking at the care plan in the resident's closet that lists the transfer rules for the resident. On 2/2/26 at 3:15 AM, an observation was made of mechanical lift slings in the laundry area. There were approximately 30 slings available with various trim colors. An observation was made of three slings with red trim hanging on the hooks positioned just inside the laundry room door. On 2/2/26 at 3:45 PM, an interview was conducted with the DON and Administrator regarding the investigation for R1 and the past non-compliance identified during the survey investigation. Education records with some staff completing the education on 1/28/26 were reviewed. Audits have been reviewed. The date of compliance was agreed as 1/28/26. The concern was identified and followed by the Quality Assurance committee. During the onsite survey, past noncompliance (PNC) was cited<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235157 | A. Building<br>B. Wing | 02/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sanilac Medical Care Facility | 137 North Elk Street<br>Sandusky, MI 48471 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | after the facility implemented actions to correct the noncompliance which included:-A review of resident transfers to ensure that residents are being transferred safely and per individualized plan of care.-Law enforcement had been contacted.-Education: Following the Resident Plan of Care; Preventing Neglect, Injury, and Licensure Consequences for Certified Nursing Assistants (CNAs) and Licensed Nursing Staff. Education was mandatory by 1/22/26 and had been completed by 1/28/26.-Audit of resident transfers to ensure that residents are being transferred safely and per individualize plan of care of 20 residents weekly for 4 weeks and then monthly for three months.-Director of Nursing responsible for sustained compliance.The State Surveyor verified the documentation provided by the facility and conducted interviews with facility staff regarding following care planned interventions and staff were knowledgeable about the facility policies. Other Residents were reviewed for injuries and following care planned interventions for transfers and noncompliance was not identified.The facility was able to demonstrate monitoring of the corrective action and maintained compliance. |