STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235157	A. Building B. Wing	08/21/2025

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

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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 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, interview, and record review, the facility failed to maintain best practices in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings include:On 08/19/2025 at 8:45AM during the initial kitchen tour with the Certified Dietary Manager (CDM) N, the rag sanitizer bucket was tested with Hydrion quaternary ammonia test strips, and the result was zero. The CDM N changed out the bucket and retested it, and the second result was between 150-200ppm. On 08/20/2025 at 9:03 AM the rag sanitizer bucket was retested with the quaternary test strips, and the result was zero. Conducted interview with the Certified Dietary Manager N on the desired concentration range for the sanitizer and she answered 50-100 ppm. When questioned about how often the sanitizer bucket was changed out, she stated that it is changed every morning and evening shift. She then proceeded to tell dishwashing staff to change out the bucket. Record review of the sanitizer with the label EPA Reg No. 10324-81, according to the product information sheet provided by the United States Environmental Protection Agency for sanitization of food contact surfaces, the dilution requirements are 150ppm for one gallon. According to the 2022 Food Code, 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness, A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation .shall be used in accordance with the EPA-registered label use instructions.

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure cleanliness of the water system and the use of appropriate backflow prevention on cross connections. This deficient practice increases the likelihood of contamination of the water supply due to uncleanliness and a potential backflow event, potentially affecting all residents, staff, and visitors who consume water at the facility. Findings include:On 08/19/2025 at 1:30PM during the environmental tour with the Director of Operations K, Maintenance Assistant L, and Maintenance Assistant M, observed the water softener brine tank filled with a black foam substance in the main boiler room. Conducted interview with Maintenance Assistant L, he stated that the brine tank is cleaned out every three years and that the cleaning is due. On 08/19/2025 at 1:45 - 2:20PM observed black foam inside the brine tank of the water softener located in the boiler room in the 800 hallway. On 08/19/2025 at 1:45 - 2:20PM observed the drain line to the water softener sitting inside the drain, located in the boiler room in 800 hallway. On 08/19/2025 at 1:45 - 2:20PM observed chemical dispenser connected to a utility sink by a hose downstream of an atmospheric vacuum breaker (AVB) without an attached wasting tee, located in the custodial closet in 600 hallway. On 08/19/2025 at 1:45 - 2:20PM observed spray nozzle attached to a hose connected to a utility sink downstream of an atmospheric vacuum breaker (AVB), located in the 700 hallway custodial closet. According to the 2008 Cross Connection Manual on water softeners, Typical water softener installations may pose a public health threat mainly due to the waste discharge piping being terminated in a floor drain or sewage piping system thereby creating a submerged inlet cross connection. According to the 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.According to the 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review, the facility failed to ensure adequate staffing to meet the care needs of the residents for a confidential group of residents, and Residents #10, # 50, #52, and #89, resulting in long call light wait times, scheduled activities being cancelled and delayed resident care. Findings include:Facility On 08/20/2025 at 2:00PM, a resident council meeting was held with a confidential group of residents. One confidential resident stated they have numerous long call light wait times. A review of call light response times revealed that on 8/16/25 the resident waited 36 minutes and 26 minutes. On 8/17/25 the resident had wait times 32 minutes, 28 minutes and 26 minutes. On 8/18/25 the resident had a wait time of 49 minutes. Another confidential resident stated, we only have one certified nursing assistant (CNA) per hall and if they are busy then we can wait too long. We need more help around here; the CNA's are so busy they can't answer call lights on time. The confidential group stated they believe the facility needs more CNA staff, they think they are too busy. They are pulling people from activities. There have been a couple of times where we haven't been able to do activities because the activity aides got pulled to the floor. A confidential resident stated they waited too long in pain and that they were in tears and hurting. The resident stated this occurred very recently but could not give an exact date. A review of the call light response times for this resident revealed that on 8/7/25 they had a 36 minute wait, on 8/11/25 they had wait times of 28 minutes, 25 minutes, and 33 minutes. On 8/14/25 they had a wait time of 40 minutes, on 8/15/25 they had wait times of 1 hour and 13 minutes, 26 minutes, 51 minutes and 57 minutes. On 8/16/25 they had wait times of 53 minutes and 56 minutes. On 8/19/25 the resident had wait times of 44 minutes and 55 minutes. One confidential resident stated, they just need more people and that management could help more as well and take the burden off the CNA's. Review of resident council notes for the last 6 months revealed the group had complaints of long call light times in April 2025 and August 2025. On 08/21/2025 at 10:11AM, an interview was conducted with the activity director (AD) J. AD J was asked if they keep track of the days your staff gets pulled to the floor. AD J replied, Yes, I keep track of when they are pulled. In August they were pulled on 8/5, 8/8, 8/9, 8/11, 8/12, 8/15, 8/18, 8/19, 8/21. In July 7/2, 7/6, 7/10, 7/14, 7/19, 7/23 and on 7/24 pulled twice. AD J stated that on a normal weekday we have 5 activity staff present. Today (8/21/25) my assistant got pulled to the floor to help out. AD J was asked if they have noticed an increase of their staff getting pulled to the floor. AD 'J stated that around May of this year it started to be more than usual and it has increased since then. AD J stated that on the weekend of August 9th one of my activity aides was pulled to the floor twice and we were unable to have any activities that day. Resident #10 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/19/25 at 12:12 PM, an observation was made of Resident #10 lying in bed. The Resident was interviewed and was able to answer questions using her computer that detected eye movement. The Resident was asked about concerns she had and indicated that she had been waiting all morning to get ready for the day, she had a care conference at 1:00 PM and reported she was still waiting for them (CNA) to get her going for the day. The Resident indicated she wanted fresh gown/clothes applied. An observation was made of whitish debris on her teeth and tongue. An observation was made of dried flaking debris to the left side of her mouth on her face. On 8/19/25 at 1:06 PM, an observation was made of Resident #10 lying in bed. When asked if staff had a chance to assist with morning care, the Resident reported she was still waiting. The Resident was asked if she had mouthcare completed and the Resident opened her mouth to show her teeth that had a whitish debris over the teeth and nods that she needs it done. The left check area had the flaking dried debris that was observed earlier. On 8/21/25 at 1:02 PM, an interview was conducted with CNA S regarding Resident #10's morning routine. The CNA reported that the Resident liked to get up about 10 or 10:30 AM for AM care for dressing, mouth care, repositioning or getting up to her chair. The CNA reported that the hall that Resident #10 resided had many Residents that needed two people to assist with care and getting up in the mornings, that it was a very heavy assignment for only two CNAs and that a float CNA would help out tremendously. CNA T was asked about Resident #10's AM care 8/19/25 and reported that it was busy in the morning and hard to get to residents timely sometimes with only two CNAs. The CNAs reported that there were about eight Residents that needed two-person assist with a mechanical lift and many residents needing to toilet more often. Resident #50: On 8/19/25 at 10:27 AM, an observation was made of Resident #50 lying in bed with her feet and lower legs elevated with boots on. The Resident was interviewed, answered questions and engaged in conversation. The Resident reported that she was paralyzed from the waist down. When asked if she had any concerns regarding her care received at the facility, the Resident stated, I am concerned about my legs getting stiff, I can't move them myself, I am supposed to get restorative therapy, but I have not had it for 2 weeks now. The Resident reported that the program made sure her legs received range of motion and that the staff that does the exercises on her legs got pulled to the floor and no one was in to do it. The Resident stated, I have limited movement of my hands, and I can do my hands myself, but I need them to work my legs, I can't do them. I am afraid they are going to get stiff. On 8/20/25 at 2:47 PM, an interview was conducted with Restorative Nurse D regarding Resident #50's restorative therapy plan. The Nurse reported that the Resident was always seen by the Restorative Therapy aide. The Nurse reviewed the last documented Restorative Therapy and indicated that 8/9/25 was the last paper that I have for Resident #50. When asked why no Restorative Therapy was completed, the Nurse reported that the Aide was pulled to the floor and if she was working that section, she would get to the Residents that were on the Restorative Therapy in that section but could not get to everyone. On 8/21/25 at 12:02 PM, an interview was conducted with Restorative Nurse D regarding Resident #50's documentation for the Restorative Program. The document revealed Resident #50 was to receive 3 to 5 times (a week). From 8/3 to 8/9 there were two marked days, Tuesday and Friday. Nurse D reported that the marked days with a X represented that the Resident had received the Restorative Therapy on those days. From 7/27 to 8/3 the Resident had three days indicated and from (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/20 to 7/26 there was one day indicated. The Nurse reported that the Restorative CNA gets pulled to the floor and if she has a resident in the area where she is working, she will get in there and do their restorative therapy plan and stated, but she can't cover the whole building when she is working the floor. We had a drop in the CNAs for the last two weeks, and she was unable to get to the Restorative therapy. Resident #52: On 8/19/25 at 10:20 AM, an observation was made of Resident #52 lying in bed. The Resident was interviewed, answered questions and engaged in conversation. The resident was asked about any concerns they had with the care received by the facility staff. The Resident reported long call light wait times and stated, I had over an hour on this last weekend. They need more staff, someone could be dying, and they wouldn't know it. The Resident expressed frustration in waiting for their call light to be answered. Resident #89: On 8/19/25 at 10:36 AM, an interview was conducted with Resident #89, who answered questions and engaged in conversation. The Resident was asked of any concerns with the care at the facility. The Resident reported that call lights can take a while to answer, and indicated a lack of staff and that the staff were too busy and could not answer call lights timely. Confidential Staff During the survey, an interview was conducted with Confidential Staff (CF) U regarding staffing concerns. The CF was asked about call lights response times and the CS stated, We try to keep up on call lights, but reported that the Residents that are not capable of using the call light do not get care like they should, not timely on a consistent basis. Confidential Resident Advocate During the survey, an interview was conducted with a Resident Representative who wanted to remain confidential. The Confidential Resident Advocate (CRA) R reported that they had concerns of under staffing and the CNAs (Certified Nursing Assistants) were over worked and mentally and physically drained. The CRA reported that their Resident has used the call light and has had to wait 30 minutes to an hour with the Resident having incontinent episodes due to having to wait to use the bathroom while waiting for the call light to be answered. The CRA reported that the CNAs had an exceptional attitude and worked very hard and that the issue was not how the CNAs worked but that the workload was too much and not enough CNAs to meet the Resident's needs timely. During the annual survey facility staff who wanted to remain anonymous reported the following regarding current staffing concerns at the facility: - Within the last two months they have lost approximately 20 certified nursing assistants (CNA's). - Since new administration they staff the units with less staff, which has effected the quality of patient care they are able to provide. - The quality of patient care has decreased given the mass exodus of staff in the last two months and (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	how management how they staff the units. - Many of the aides left due to low wages and the increase in mandations. - Aides are leaving the facility due to the workload and lack of pay. It has affected the quality of patient care they can provide. On 8/20/2025 at 3:25 PM, an interview was conducted with Scheduler P she shared she has been mandating more and recently she was mandating daily due staffing concerns. They lost an extensive amount of CNA's in the last few months and she was not expecting it, so they are struggling to cover many of the shifts. They schedule the facility based off PPD and she is uncertain of the resident acuity of the unit. They typically have a float but when an aide calls in, they pull the float to work the regular assignment. She was asked if the restorative aide is pulled as well and she reported last week she pulled the aide everyday due to their 1:1. Scheduler P reported her staff have shared they are becoming burned out from working so many hours.

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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 observation, interview and record review, the facility failed to prevent verbal abuse for one (Resident #40) of 19 residents reviewed for abuse, resulting in refused care, frustration with the likelihood of increased behavioral disturbances. Findings include:This citation pertains to intake 2594908 On 8/19/2025, at 12:10 PM, Resident #40 was asked if they were happy with their room and Resident #40 offered, that it was a new room. Resident #40 complained there was a girl that worked there and that they had laughed at their grandmother. Resident #40 offered, that they always say hi to them but this girl has got it in for me. Resident #40 was unable to detail the girl's appearance other than she wore pink outfits. On 8/19/2025, at 12:30 PM, the Director of Nursing (DON) offered, they called CNA H to interview them regarding Resident #40 as they left out of the facility prior to the DON arriving. The DON stated, that CNA H was alerted they would be reported for verbal abuse and that CNA H stated, no worries, I quit. On 8/19/2025, at 10:00 AM, a record review of Resident #40's electronic medical record revealed an admission on [DATE] with diagnoses that included Stroke, Dysphagia, adjustment disorder with anxiety and major depressive disorder. Resident #40 required assistance with all Activities of Daily Living and had recently been deemed incompetent to make medical decisions for themselves. A review of the care plan The resident uses psychotropic medication(s) to manage symptoms of their psychiatric disorder(s). Date Initiated: 02/28/2025 Goal My symptoms/behaviors will be reduced using a combination of psychotropic medication(s) and nonpharmacological interventions through the review date. Date Initiated: . Approaches/Tasks . Provide me with a non-confrontational environment for care. Date Initiated: 02/28/2025 . On 8/20/2025, at 9:20 AM, Resident #40 was resting in bed on back and denied any abuse complaints that day. On 8/20/2025, at 3:27 PM, a phone interview was conducted with CNA I who witnessed the verbal abuse towards Resident #40. CNA I stated, earlier that day they were in caring for Resident #40 and had asked CNA H to bring in the hoyer and assist with a transfer out of the bathroom. CNA I asked Resident #40 if CNA H could assist with the transfer and Resident #40 stated, Nope, get out. At that time, CNA I witnessed, CNA H open the bathroom door hastily and stated to Resident #40, I did nothing to you and you tried to kill me as CNA H attempted to slam the bathroom door shut but CNA H quickly stopped the door from slamming, opened back up and stated to Resident #40, You're crazy and slammed the bathroom door shut before leaving out of the room. CNA I stayed with Resident #40 who complained about CNA H stating, she hates me and that she's out to get me. CNA I completed cares for Resident #40 and propelled them down to the dining room. As CNA I pushed Resident #40 into the dining room, CNA H was overhead and observed pointing towards both Resident #40 and CNA I and loudly stated, and that dumb ass over there wants to call me crazy when she's the crazy one. She tried to kill me. She thinks my grandma's here, and she doesn't even know what she's talking about. CNA I continued to propel Resident #40 towards a dining table and CNA H further stated loudly, At least I'm an independent woman and do things for myself and get my own drinks. CNA I was asked if Resident #40 overheard the abuse and CNA I stated, yes and had to provide reassurance of everyone needs to get along to the resident. CNA I called the Director of Nursing (DON) and alerted of the verbal abuse towards Resident #40 by CNA H . On 8/20/2025, at 10:34 AM, a phone interview was conducted with CNA H regarding the verbal abuse allegation towards Resident #40. CNA H was asked if they called Resident #40 a dumb ass and CNA H stated, they were going to help with a Hoyer lift and the resident said I couldn't help her and that Resident #40 told CNA I they didn't want me to care for her because I was mean to her grandma. She's not right. A week ago, she tried to stab me with a pen. She isn't cognitive. CNA H was asked if they called the resident crazy and CNA H stated, I did not call her crazy. CNA H was asked to explain what happened next and CNA H stated, the resident was on the toilet and they left to the dining room where they were putting meal trays on the cart. CNA H admitted (continued on next page)

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	235157	A. Building B. Wing	08/21/2025

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to venting loudly and did admit saying this is some dumb shit. CNA H was asked if there were residents in the dining room and CNA H stated, yes, but they had their back to the residents, was approximately 10 feet away and didn't use resident names. CNA H was asked why they would be accused of verbal abuse and CNA H stated, the nurse has it out for them and that they did not swear in Resident #40's room, that was crazy and further stated, they knew venting in the dining room was wrong and they did not do what they are being accused of.

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	235157	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening/Annual Resident Review (PASARR) form DCH-3877 and DCH-3878 were completed for one resident (Resident #67) of two residents reviewed for PASARR evaluation.Findings Include: A review of Resident #67's medical record revealed an admission into the facility on 7/30/2003 and readmission on [DATE] with diagnoses that included history of traumatic brain injury, anxiety, mood disorder, mental disorder due to known physiological condition, dementia and need for assistance with personal care. A review of the Minimum Data Set assessment revealed the Resident had severely impaired cognitive skills for daily decision making and was dependent on helper for activities of daily living and mobility. A review of Resident #67's medical record revealed PASARR Level I Screening dated 10/12/2023. The form (Form-3877) indicated Section II-Screening Criteria items 1-6 revealed the following:-1. Yes, The person has a current diagnoses of Mental Illness-2. Yes, The person has received treatment for Mental Illness-4. Yes, There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others; with explain any yes, Dx (diagnoses) of anxiety mood disorder and TBE prescribed Buspar.The Form-3877 had directions that indicated, Distribution: If any answer to items 1-6 in Section II is Yes, send one copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.Resident #67's medical record lacked a DCH-3878 exemption request or information that a Level II screen had been completed. The medical record lacked communication from CMHSP.On 8/21/25 at 9:33 AM, an interview was conducted with Social Services Q regarding Resident #67's PASARR information. SS Q reported that have not been doing the PASARR for the facility and that the Director of Nursing would have the information on the PASARR forms. Resident #67's PASARR forms and Level II screening information were requested. On 8/21/25 at 9:50 AM, an interview was conducted with the Director of Nursing (DON) regarding Resident #67's PASARR information. The DON had the PASARR Form DCH-3877, dated 10/12/2023. The DON reported they did not have any other information and stated, The last one was done October 2023. We don't have anything for 2024. I seen it yesterday and sent one out to the health department. The DON reported she had looked for a letter from the health department and stated, I can not find one for 2023, and reported having problems accessing into the website to generate the letters. The DON stated, We did not do one for 2024.

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	235157	A. Building B. Wing	08/21/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failure to ensure availability and accurate documentation for Lexapro (antidepressant medication) for one resident (34) of 5 reviewed for medication management, resulting in Resident #34 not receiving her medications for approximately three weeks and imprecise medication administration documentation.Findings Include:On 8/20/2025 at approximately 9:15 AM, a review was conducted of Resident #34's medical record and it indicated she admitted to the facility on [DATE] with diagnoses that included Dementia, Hyperlipidemia, Hypertension, Adjustment Disorder with mixed anxiety and depressed mood and Anxiety. Further review revealed the following:Physician Orders:Lexapro Oral Tablet 5 MG (milligram)- Give one tablet by mouth one time a day for agitation, irritability, depressed mood.August 2025 MAR (Medication Administration Record)Of the twenty days reviewed on the MAR, Lexapro was administered 10 times. It can be noted Resident #34 did not have lexapro available for the facility to administer. The documentation in the MAR is erroneous.Progress Notes:7/29/2025 15:18: Per Pharmacy (outside pharmacy that mails Resident #34's medications)., Lexapro prescription needs to be renewed in order to be filled. Message sent to.PA (physician assistant). 8/18/2025 13:30: Phone call to Pharmacy. to determine when next order for Lexapro is being sent; has had no Lexapro for at least 2 weeks. Per pharmacy, last order was filled Dec. 2024 and no order requested since that time. Daughter. handles ordering medications through Pharmacy. and notified of need for medication by staff; currently out of the country.but available by phone. 700 hall med nurse left message for daughter to call. Per pharmacy, will expediate shipment for 90-day supply to daughter. 8/19/2025 09:00: Called Pharmacy.for status on Lexapro. Order is in process to be sent out for mail delivery today; however, it does take 5-7 days.On 8/20/2025 at approximately 1:00 PM, Resident #34 was observed sitting in the common area. She was well dressed and pleasant. On 8/20/2025 at 1:30 PM, Clinical Care Coordinator O was asked why Resident #34 had not received her lexapro in three weeks. She explained the resident's daughter orders the medication from an outside pharmacy, the pharmacy ships the medication to the daughter, who in turn brings it to the facility. At the end of July or early August, a nurse informed her she administered the last pill (lexapro) and when she called the outside pharmacy she was informed there were no refills left on the prescription. Coordinator O contacted the physician and requested a refill. About a week later she followed up with the pharmacy and they again said she did not have any refills. Coordinator O stated she believes the doctor forgot to call in the refill. She called the physician again and when they followed up this week, they stated they were filling the script but it would still be a few days before Resident #34's daughter received the medication.Coordinator O was unsure why the family was not utilizing the facility pharmacy. The coordinator was informed some of her nurses were documenting they were administering Lexapro to Resident #34. She was asked what medication were the nurses giving, since lexapro has not been available in three weeks. Coordinator O reported she did not know what medication the nurses were giving. She was asked if another resident is prescribed Lexapro and she stated yes , but it is a different dosage.Coordinator O shared the medication was not available in backup and an observation was made of the backup medications machine and it indicated Lexapro was not a medication that was offered. Furthermore, review was conducted of 700 medication cart and Resident #34 had the following medications accounted for:2 blister packs of Lisinopril 30 mg1 blister pack of Methenamine Hippurate 1 mg1 bottle of Docusate Sodium 100 mg1 bottle of Lisinopril 30 mg1 bottle of Acetaminophen ER (extended release) 650 mg1 bottle of Amlodipine 5 mg Resident #34 did not have Lexapro available in the medication cart.There is one other resident on 700 hall that is prescribed Lexapro at 10 MG daily. On 8/20/2025 at 2:30 PM, the DON (Director of Nursing) reported she found out about the issues with the Lexapro during their morning meeting on Monday. Typically, they will address things of that nature in morning meetings so they are all on one accord and can follow up as needed. It is a unique situation as the resident (continued on next page)

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	235157	A. Building B. Wing	08/21/2025

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Sanilac Medical Care Facility	137 North Elk Street Sandusky, MI 48471

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receives her medication from an outside pharmacy, and she is not fully abreast of why that is.The DON was informed that some facility nurses were charting they administered Lexapro throughout the month when it was not available. The DON reported this should not have occurred as its inaccurate documentation.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure restorative therapy services were provided for two Residents (#36 and 50), of three reviewed for limited range of motion. Findings include: Resident #36 On 8/20/2025, at 2:15 PM, a record review of Resident #36's electronic medical record revealed an admission on [DATE] with diagnoses that included muscle weakness, difficulty in walking and need for assistance with personal care. Resident #36 required assistance with all Activities of Daily Living and had intact cognition. A review of the physician orders revealed NURSING REHAB/RESTORATIVE: ACTIVE ROM Program AROM: Dumb bells 2# 2x15 BI/TRI-2.5 # A.W 2x25 kicks, knee lifts, hip Abd/add and ankle pumps. Static standing x3 to tolerance performing task. Start: 7/31/2025 End: 8/28/25. NURSING REHAB/RESTORATIVE: Walking Program 3 x week CGA FWW 150x2 no WC to follow: Start: 7/31/25 End 8/28/25 A review of the The resident has limited physical mobility r/t (related to) weakness Date Initiated: 04/23/2025 The resident will demonstrate the appropriate use of Therapy ordered device(s) to increase mobility through the review date. Date Initiated: 04/23/2025 Revision on: 07/25/2025 . Approaches . AMBULATION: The resident is able to: 1 assist using 2WRW (wheeled roller walker) room dining room, per therapy w/c (wheelchair) not to follow. Date Initiated: 04/23/2025 . NURSING REHAB/RESTORATIVE: ACTIVE ROM (range of motion) program AROM: (active range of motion) Dumb bells 2# 2 x 15 BI/TRI-2.5# A.W 2 x 25 kicks, knee lifts, hip Abd/add and ankle pumps. Static standing x 3 to tolerance performing task. Start: 7/31/25 End: 8/28/25. Date Initiated: 07/31/2025 . NURSING REHAB/RESTORATIVE: Walking Program 3 x week CGA FWW 150 x 2 no WC to follow. Start: 7/31/25 End: 8/28/25. On 8/20/2025, at 2:24 PM, CNA F was interviewed regarding the documented completion on the task list for Resident #36's ambulation that day. CNA F was asked where Resident #36 ambulated. CNA F offered that they had walked with the resident back and forth from their chair into their bathroom inside their room two times. On 8/20/2025, at 2:26 PM, CNA G was asked if they walked with Resident #36 that day and CNA G offered that they walked back and forth from their chair to the bathroom just one time. On 8/20/2025, at 2:27 PM, Both CNA's F and G were asked if they had walked in the hallway with Resident #36 and both said, no. On 8/20/2025, at 2:39 PM, The Director of Nursing (DON) was asked regarding the task list being check marked completed of ADL AMB 4WW 200 ft SBA no WC to follow and the DON stated, they can ambulate up to 200 feet safely with SBA with the 4 ww. The DON was asked if there was a check mark on the task list if that meant the resident ambulated the 200 feet and the DON offered, yes. On 8/21/2025, at 10:05 AM, Restorative Nurse (RN) D was interviewed regarding Resident #36's (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restorative therapy progress and how many visits they had received and RN D provided that Resident #36 only had the one day. RN D was asked for all documented completion of their restorative nursing visits. A record review of the restorative notes RN D provided revealed Week of: 7/27/8-2-25 Restorative Program Resident #36 did not receive any restorative therapy for their first week. For Thurs there was an X and for Fri there was nothing noted. For the Week of: 8-3/8-9-25 . Tues there was an X documented. For Wed Thurs they were left blank. On the bottom of the document, There was a handwritten note: pulled to 8's 6-2 under the Wed column and pulled to 8's 6-10 & 7's 10-2. There was an R written in the Fri column. RN was asked why Resident #36 did not receive any restorative therapy for the second week and RN D offered, I only have one Restorative CNA and they got pulled to the floor for resident care and couldn't offer restorative therapy. RN D was asked if they review the restorative completion documents daily and RN D stated, no the restorative CNA fills it out and hands it in on Friday's. On 8/21/2025, at 10:38 AM, Resident #36 was resting in their recliner in their room and offered that they walk to and from the bathroom with the staff and did not mention if they were doing their exercises and how often. On 8/21/2025, at 10:42 AM, Clinical Nurse B was asked regarding Resident #36's restorative therapy and their progress. Clinical Nurse B offered that Resident #36 had not been getting restorative therapy as ordered and Resident #36's wife had brought that to their attention the day prior and was upset. On 8/21/2025, at 12:05 PM, RN D offered, they met with Resident #36 and placed a new order for the resident to walk to the dining room for breakfast. RN D was asked if they offer restorative exercises when the Restorative CNA gets pulled to work as a care CNA and RN D stated, that they do wounds also and do not have time to offer the exercises. Resident #50 A review of Resident #50's medical record revealed an admission into the facility on [DATE] with diagnoses that included incomplete paraplegia, disease of spinal cord, cervical disk disorder with myelopathy, reduced mobility, muscle weakness and need for assistance with personal care. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 15/15 that indicated intact cognition and was dependent on a helper for toileting and personal hygiene, bathing, dressing, chair/bed to chair transfer and roll left and right. On 8/19/25 at 10:27 AM, an observation was made of Resident #50 lying in bed with her feet and lower legs elevated with boots on. The Resident was interviewed, answered questions and engaged in conversation. The Resident reported that she was paralyzed from the waist down. When asked if she had any concerns regarding her care received at the facility, the Resident stated, I am concerned about my legs getting stiff, I can't move them myself, I am supposed to get restorative therapy, but I have not had it for 2 weeks now. The Resident reported that the program made sure her legs received range of motion and that the staff that does the exercises on her legs got pulled to the floor and no one was in to do it. The Resident stated, I have limited movement of my hands, and I can do my hands myself, but I need them to work my legs, I can't do them. I am afraid they are going to get stiff. On 8/20/25 at 2:47 PM, an interview was conducted with Restorative Nurse D regarding Resident #50's restorative therapy plan. The Resident's restorative therapy plan was reviewed with the Nurse (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who indicated the Resident was passive range of motion for upper and lower extremities but reported that the Resident was off of the plan as of 7/10/25. The Nurse reported that Restorative Therapy was for a set amount of time and that when Resident #50 goes off, they re-add her. The Nurse reported that the Resident was always seen by the Restorative Therapy aide. The Nurse reviewed the last documented Restorative Therapy and indicated that 8/9/25 was the last paper that I have for Resident #50. When asked why no Restorative Therapy was completed, the Nurse reported that the Aide was pulled to the floor and if she was working that section, she would get to the Residents that were on the Restorative Therapy. The Nurse reported that there was not staff that covered and stated, Therapy is supposed to help but they have a full boat, and they can't do it. We had like 20 CNAs that just quit at once. The Nurse reported that the Resident needed Restorative Therapy for both the upper and lower. A review of Resident #50's documentation titled, Rehab Discharge Notice, dated 8/19/25, revealed, ROM: PROM (passive range of motion) to BUE (bilateral upper extremities) all joints 15 x2 to tolerance. Other: PROM to BLE (bilateral lower extremities) ankle flexion/extension, knee flexion/extension, hip abduction/adduction, hip flexion/extension 15x2 to tolerance. On 8/21/25 at 12:02 PM, an interview was conducted with Restorative Nurse D regarding Resident #50's documentation for the Restorative Program. The document revealed Resident #50 was to receive 3 to 5 times (a week). From 8/3 to 8/9 there were two marked days, Tuesday and Friday. Nurse D reported that the marked days with a X represented that the Resident had received the Restorative Therapy on those days. From 7/27 to 8/3 the Resident had three days indicated and from 7/20 to 7/26 there was one day indicated. The Nurse reported that the Restorative CNA gets pulled to the floor and if she has a resident in the area where she is working, she will get in there and do their restorative therapy plan and stated, but she can't cover the whole building when she is working the floor. We had a drop in the CNAs for the last two weeks, and she was unable to get to the Restorative therapy.

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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 observation, interview and record review, the facility failed to ensure that an indwelling urinary catheter bag and tubing were not in contact with the floor during transport of the Resident through the dining area and hallway and when the Resident was seated in their wheelchair in their room, for one Resident (#2), of two reviewed for indwelling urinary catheters. Findings include:A review of Resident #2's medical record revealed an admission into the facility on 4/30/25 with diagnoses that included diabetes, pressure ulcer of sacral region Stage IV, need for assistance with personal care, and dementia. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 8/15 that indicated moderately impaired cognition, and the Resident was dependent on helper for activities of daily living, transfers and mobility. Further review of the medical record revealed the Resident had an indwelling urinary catheter. On 8/19/25 at 12:56 PM, an observation was made of Resident #2 in the dining room for the lunchtime meal. The Resident was seated in a wheelchair and was positioned up to the table. An observation was made of a urinary catheter bag inside a privacy bag. The bags were positioned underneath the wheelchair and laying on the floor. The Resident was observed to be moved from the dining area by a staff member and pushed in the wheelchair out of the dining room. The bag was dragging on the ground and could be heard dragging on the floor as they passed by. The Staff did not stop to adjust the catheter bag and tubing but continued down the hall to the Resident's room. On 8/20/25 at 12:52 PM, an observation was made of Resident #2 in the dining room for the lunchtime meal. The urinary catheter bag is inside the privacy bag that was hanging from the seat area of the wheelchair and partially lying on the floor. The Resident was observed to be pushed by staff through the dining area, down the hall to her room with the bag dragging on the floor. On8/20/25 at 1:40 PM, an interview was conducted with the Infection Control Preventionist (ICP), Nurse E regarding placement of a catheter bag and privacy bag of an indwelling urinary catheter. The ICP Nurse reported that the tubing and the bag should not be touching the floor. An observation was made with the ICP Nurse of Resident #2 sitting in the wheelchair in her room. The urinary catheter was in a privacy bag that was partially laying on the floor and the tubing of the urinary catheter was lying on the floor. The ICP Nurse reported that the Resident did not have a urinary tract infection and recently has been getting out of bed. The ICP Nurse reported the bag and tubing should be positioned so neither the tubing nor the bag was on the floor. The ICP Nurse applied gloves and adjusted the bag and tubing. The ICP Nurse indicated that education would be provided to staff. A review of facility policy subject Catheter Care, with an effective date 1/13/09, revealed, .Purpose: To prevent infection within the urinary system. Procedure: . 14. Privacy bags will be changed out when soiled, with a catheter change or as needed. Privacy bags are not to be in direct contact with the floor.