STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain best practices in accordance with professional standards of food service safety. The deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen.Findings include: 09/02/2025 at 9:27AM, observation of a beverage pitcher found brown and white dried liquids on it. The pitcher was stored with other pitchers and storage containers on a shelf under the prep table. Certified Food Manager (CFM) BB confirmed that this area was where cleaned ready to use containers were stored. On 9/2/25 at 10:33 AM, observation of the kitchen ice scoop holder found an increased accumulation of white and brown crusted debris at the bottom inside of the holder. On 9/2/25 at 12:22 PM, observation of the meat slicer found an increased amount of dried meat debris on the back blade and back top portion of the unit. An interview at this time with CFM BB found that staff don't use the slicer and to her knowledge it hasn't been used in a couple of weeks. Upon showing CFM BB the slicer, she stated they would remove it from the kitchen. On 9/2/25 at 12:27 PM, observation of the clean mechanical scoop drawer found excess crumb debris lined up in the back corners of the drawer. Further review found that the drawer only opens halfway, making it hard for staff to clean effectively or know when excess debris may accumulate. On 9/3/25 at 7:55 AM, observation of the two door Horizon cooler found increased accumulation of debris on the top side of the door gaskets. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 09/02/2025 at 9:40AM, observation of the drain line for the hand sink found that it was the same drain line for the ice machine. Following the drain line from the hand sink, it was observed that little to no slope was evident, allowing the potential for regular discharge from the hand sink to make its way to the ice machine. These lines should be separated. According to the 2022 FDA Food Code section 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified (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
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	under Subparts 3-301 -3-306. On 9/2/25 at 10:37 AM, observation of the Forest Unit water pass station found that the cooler containing ice for hydration pass was not fitted with the means to self-drain, allowing the ice for consumption to comingle with the melted ice water in the cooler. On 9/2/25 at 10:47 AM, observation of the [NAME] Unit water pass station found the cooler containing ice for hydration pass was not fitted with the means to self-drain, allowing the ice for consumption to comingle with the melted ice water in the cooler. At this time, it was observed that the contents of the cooler were half water and half was ice. On 9/2/25 at 12:30 PM, An interview with CFM BB found that Certified Nursing Assistants (CNA's) take care of the hydration pass and ice chests on the units. When asked who cleans the coolers, CFM BB stated that third shift staff clean and sanitize the units. According to the 2022 FDA Food Code section 3-303.12 Storage or Display of Food in Contact with Water or Ice.(B) Except as specified in ¶¶ (C) and (D) of this section, unPACKAGED FOOD may not be stored in direct contact with undrained ice. On 9/3/25 at 8:02 AM, observation of the kitchen cutting boards found the white cutting board was stained with orange and brown debris while having some deep cut marks on the board. When asked about using the cutting board, CFM BB stated it should be re-surfaced or not used. When asked if there were other pieces of equipment that need repair in the kitchen, CFM BB stated that the plate warmer only has one side that works and that staff must work off the one side and place the plates back and forth and keep a cover on the side that doesn't work in order to keep the plates hot. On 9/3/25 at 2:00 PM, observation of the Freezer #3 found that both doors of the unit had gasket seals that were ripped and torn in the middle of the doors. According to the 2022 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility.Findings include:On 9/2/25 at 10:14 AM, observation of the drink station in the kitchen found that a water line to the left of the hand sink was not connected to anything and indicated a stagnant water line. 09/2/2025 10:37 AM, observation of the Forest Pantry found a dish machine that was not connected to a wastewater line and water lines where a stackable washer and dryer would go, but nothing connected to the water fixtures at this time, indicating a stagnant water line. On 9/2/25 at 10:47 AM, observation of the [NAME] Pantry found a dish machine and a washer in this room with both units' showing accumulation of debris on the inside, indicating they have not been used or flushed, indicating a stagnant water line. On 9/2/25 at 11:45 AM, an interview with Certified Food Manager BB found that the dish machines in the pantry's are not used. On 9/2/25 at 1:44 PM, observation of the Forest Unit spa room found the walk-in tub was holding items such as trash bags with debris found in the bottom of the tub, indicating the tub not used regularly and the tub's plumbing could be a stagnant water line. On 9/2/25 at 2:00 PM, observation of the [NAME] South spa room found a walk-in tub with multiple items stored inside of the tub and an accumulation of debris in the bottom of the tub. This indicates that the tub is not used regularly and could be a stagnant water line. On 9/3/25 at 8:16 AM, an interview with Maintenance Director (MD) AA found that the facility does have flushing Fridays, where staff flush some fixtures in the facility. When asked if items in the pantry's, such as dish machines or water fixtures for the washers are flushed on these Fridays, MD AA stated those water lines were not part of the flushing schedule. When asked if the facility uses the tubs in the spa rooms, MD AA stated the facility is not using the tubs to his knowledge. When asked if the tubs are a part of the facilities flushing schedule, MD AA stated they were not. On 9/3/25 at 10:10 AM, observation of the Central Supply room, off the service hall, found that the room had been converted from a locker room or shower room. In the back of the room, it was observed that a [NAME] valve for commode was sticking out of the wall, when asked if this was a plumbing fixture that gets flushed, MD AA stated it was not. Onsite record review of the Water Management Program (WMP) found the risk assessment stated the facility had 5 bladder tanks in a well house and one of the control limits was Aerator cleaning. On 9/3/25 at 12:27 PM, nn interview with MD AA found that he was unsure why it stated there were bladder tanks and a well house as the facility does not have either. When asked if part of his control measures were taking off aerators and sanitizing them, MD AA stated it was not something that is currently done. When asked about taking free chlorine samples in the facility, MD AA stated that the city takes free chlorine samples from the municipal supply of cold water as it enters the facility, but he just received a free chlorine tester a week or so ago and has not started collecting samples for hot and cold supply in the facility yet. A review of the facility provided document entitled Legionella Plan Overview Control Measures and Corrective Actions, not dated, stated that, Maintenance and or designee will flush plumbing fixtures during times of changes in water pressure or temperatures, main breaks or changes in water quality and water stagnation. Further review of the document found under the section heading Risk Areas Analysis: that, The facility doesn't have dead ends or plumbing concerns. The only plumbing areas that could contain stagnant water have been identified in vacant resident rooms that have been vacant more than 30 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide meaningful and engaging activities of interest for two of two residents reviewed (Resident #2 and Resident #6), and failed to provide activity programming during the week, potentially affecting the total census of 46. Resident #2 (R2) Review of the medial record revealed R2 was admitted to the facility 01/08/2021 with diagnoses that included type 2 diabetes, frontotemporal neurocognitive disorder (type of dementia), legal blindness, polyosteoarthritis (arthritis in five or more joints), diabetic polyneuropathy (weakness, numbness, and pain from nerve damage caused by diabetes), obesity, lymphedema (swelling caused by blocked lymphatic system), tachycardia, bradycardia, chronic kidney disease, and anemia (low red blood cells). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/30/2025, demonstrated a Bried Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. During observation and interview on 09/03/2025 at 09:16 a.m. R2 was observed sitting at the side of his bed. R2 explained that the facility did not have enough activities to keep his interest and suggested that the facility would provide more options and more activities. A facility activity calendar was posted on a bulletin board, over R2's bed, but was not for the current month of September, but was for the previous month of August. During observation and interview on 09/05/2025 at 09:04 a.m. R2 was observed sitting at the side of his bed. A facility activity calendar was posted on a bulletin board, over R2's bed and appeared to be for the month of September Activities. R2 could not answer when the September Activity Calendar was provided. R2 explained that no one had invited him to any activities in a very long time. R2 again explained that he desired the facility to provide more activities daily. Resident #6 Review of the clinical record, including the Minimum Data Set, dated [DATE] revealed R6 was admitted to the facility with diagnoses that included major depression, obesity and dementia. R6 scored 12 out of 15 (moderated cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 09/02/2025 10:15 AM, during a bedside interview with R6, it was reported the Activity Director resigned about one month ago and the new person has not started. R6 reported there was nothing fun or entertaining to do at the facility and R6 reported being very bored. The main hallway of the facility had a large board that was to post the Activities for the week, however the board in blank and the Activity calendar was not posted until 09/04/2025. Review of R6's care conference notes dated 8/06/25 revealed R6 reported there was not enough activities to do and would like new things implemented and more [NAME] dye and sand art. On 09/04/2025 at 10:43 AM, during an interview with Certified Nursing Assistant (CNA) Y it was reported that the former Activity Director was currently working as a CNA on the midnight shift and resigned from the Activity Director position approximately a month ago. When queried who was currently providing activities, CNA Y stated they sometimes had a part time lady that comes on the weekends and there has been nobody doing activities during the week. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R6's activity care plan last updated 8/01/25 revealed R6 enjoyed bingo, manicures, crafts, exercise programs and intellectual programs and enjoying time outside (weather permitting). None of these activities were observed during the survey dates of 9/2 to 9/8/25. Of note, the weather was suitable to sit outside. Review of R6's last Activity assessment was dated April 2021. On 09/08/2025 10:22 AM Interview with Regional Clinical Director O verified there had been no weekly activities for approximate a month and the Activity department currently had one part time person that worked weekends and that R6 had not been reevaluated for activity preferences likes and dislikes in over 4 years.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on observation, interview and record review, the facility failed to ensure the facility Activity Director met the criteria as a qualified activities professional in a current facility census of 46 residents.Upon observation of the main hallway of the facility on 09/02/25 it had a large board that was to post the Activities for the week. However, the board was blank and the Activity calendar was not posted until 09/04/2025. Review of the September activity Calendar offered activities 7 days a week, the latest activity held was 3:30 PM. Some of the titled Activities were Morning News, Church Packets Conversation ball. There were zero activities observed during the survey week of 9/02-09/08/25. On 09/08/2025 at 10:10am, during an interview with Nursing Home Administrator (NHA) A she reported being new to the facility and the suggested surveyor talk with Clinical Regional Director O because Activity Director/Certified Nursing Assistant Z now works as a CNA. On 9/08/2025 10:22 AM, during an interview with Clinical Regional Director O reported the facility had hired a new Activity Director and their first day was to be 9/08/25. The September Activity Calendar was reviewed with Clinical Regional Director O reported the Activity Director/CNA Z made the Activities calendar and was unable to explain what was entailed with the above-named activities. Regional Clinical director O agreed the calendar was sparse and offered nothing in the late afternoon or early evening to accommodate some of the facility's population. A review of Activity Director Z's qualifications was requested at this time. On 09/08/25 at 11:32am Regional Clinical Director O reviewed Activity Director/CNA Z personal file and it was discovered upon her being hired for the Activity Director position Activity Director/CNA Z did not have license, registration or certification as a recreation specialist or as an activity professional by a recognized accrediting body, nor did Activity Director/CNA Z have two years' experience in a recreational program within the last 5 years, or completed a training course approved by the State Agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to conduct monthly pharmacy reviews for one resident (#5) of five resident reviewed for pharmacy services and the facility failed to implement/respond to pharmacy recommendations for four residents (#3, #5, #28, #46) of five residents reviewed for pharmacy services. Review of the medical record reflected R46 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included need for assistance with personal care. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/19/25, reflected R46 scored 12 out of 15 (moderately impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 9/9/25 at 1:30 PM, R46 was observed in her room. R46 was in bed and was pleasant and nicely groomed. Review of R46's medical record revealed a Pharmacist Drug Regimen Review for 6/2025, which revealed See report for any noted irregularities and/or recommendations. No copy of the pharmacy recommendations was found scanned into R46's medical record. Resident #5 Review of the clinical record revealed Resident #5 (R5) was readmitted to the facility on to the facility on [DATE] and received hospice care. A review of the monthly medication reviews revealed there was no documentation to support a medication review was completed for December 2024, January, April and May 2025. The monthly pharmacy review dated 2/12/25 reflected R5 received omeprazole 40 milligrams (mg) twice daily and the pharmacy recommended to decrease omeprazole to 20 mg twice daily 30-60 minutes before meals, tapering as tolerated. There was no documentation to support the pharmacist recommendation was not acted upon, either agreeing or disagreeing with the recommendation or signed by the provider. Resident #3 Review of the clinical record revealed Resident #3 (R3) was admitted to the facility on [DATE] with diagnoses that include paranoid schizophrenia, dementia, diabetes and heart failure. Review of the Minimum Data Set (MDS) dated [DATE] revealed a score of 10 out of 15 on the Brief Interview for Mental Statis (BIMS). Review of R3's monthly medication reviews revealed a pharmacy recommendation dated 11/20/24, revealed the provider was to consider gastroprotection with pantoprazole 20 mg once daily. There was no signed response from provider for this recommendation. Review of R3's pharmacy recommendation dated 12/10/24 was for the provider to please evaluate if Hyoscyamine is still needed & please considering discontinuing due to lack of use. (Artificial tears) there was no signed response from provider. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/05/2025 9:33 AM, during an interview with Regional Nurse Consultant O and director of Nursing (DON)B they were aware of missing documents and unanswered/no response to pharmacy from the provider. It was reported the facility had gone through a lot of changes in clinical management and director of nursing positions and pharmacy reviews were not being tracked and addressed as required. Findings Included: Resident #28 (R28) Review of the medical record revealed R28 was admitted to the facility 02/03/2024 with diagnoses that included end stage renal disease, cellulitis of right lower limb, type 2 diabetes, morbid obesity, binge eating disorder, Charcot's arthropathy (condition that causes severe damage to the joints in feet and ankles), peripheral neuropathy (weakness, numbness, and pain from nerve damage), hyperlipidemia (high fat content in blood), depression, adjustment disorder, gastro-esophageal reflux, dependence on renal dialysis, chronic kidney failure, and peripheral vascular disease (PVD). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/28/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. During observation and interview on 09/05/2025 at 09:08 a.m. R28 was observed lying on his bed. R28 appeared well groomed. R28 explained that he had been at the facility over a year and explained that he had no concerns with the care at the facility. Review of R28's medical record revealed a Pharmacist Drug Regimen Review, dated 06/12/2025 which revealed See report for any noted irregularities and/or recommendations. No copy of the pharmacy recommendations was found scanned into R28's medical record. During an interview on 09/08/2025 at 09:25 a.m. Regional Clinical Director (RCD) O explained that a contracted pharmacist conducted monthly reviews of all resident physician orders. RCD O explained that documentation would be record on the Pharmacist Drug Regimen Review document as eighter no recommendations or documented to see report for any noted irregularities and/or recommendations. RCD O explained that if there were recommendations/actions requested by the pharmacist that those were sent to the Director of Nursing (DON). RCD O explained that the DON would then review that recommendation with the physicians, obtain a signature from the physician agreeing or disagreeing with the pharmacist recommendations, and then write the order as appropriate. RCD O explained that the DON which was employed at the time of document was no longer employed by the facility. RCD O explained that the Pharmacist Drug Regimen Reviews, dated 06/12/2025 for R28 and 06/2025 for R46 could not be found.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program.Findings Include:Resident 104-1 (R104-1) Review of the medical record reflected that R104-1 was admitted to the facility on [DATE], hospitalized on [DATE] and was readmitted to the facility on [DATE]. Diagnoses of Displaced [NAME] fracture of left tibia, subsequent encounter for closed fracture with routine healing, need for assistance with personal care, Unsteadiness on feet. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] revealed R104-1 had a Brief Interview of Mental Status (BIMS) of 15 (Cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R104-1 needed assistant with personal care. During a record review for a bed hold policy, transfer notice, discharge notice, there was not given nor documented that one was discussed for R104-1. During an interview on [DATE] at 4:00 PM, Director of Nursing (DON) B stated he would have medical records look for R104-1's transfer paperwork. During an interview on [DATE] at 4:18 PM, DON B stated he was having medical records uploaded the documents as it was on his desk and he was waiting for someone to sign it. When asked if he documented that he had started this form, he stated he would hope he put in a progress note. During a record review following the interview with DON B on [DATE] at 4:18 PM, there was no nursing progress note regarding the initiation of the bed hold policy, transfer policy or discharge policy in the resident's medical records. During an interview on [DATE] at 8:40 AM, DON B stated it was never reported that residents was sent out. Staff were supposed to report these events to one of three managers when a resident was sent out to the hospital. DON B stated he didn't know how this didn't show up when they did their audits. Writer asked if they ended up finding the bed hold policy and transfer notice on this resident. DON B stated he did not write a progress note in the medical chart when this resident was sent out. DON B then stated he filled one out as of this date and would provide a copy of it. DON B also stated he had started a folder with discharged resident with bed hold policy, transfer information and discharge policy. During an interview on [DATE] at 11:25 AM, R104-1 stated he got back to the facility yesterday afternoon. R104-1 stated he had to have survey again on his left lower leg, it was infected, removed hardware and then replaced hardware. Asked if he had a discussion or received bed hold/transfer/discharge paperwork before going to the hospital for surgery, he stated no. When asked if he knew what the bed hold policy/ transfer/discharge paperwork met for him. He stated no. When asked if staff told him they would hold his bed open for him, he stated no. When asked if staff discussed these forms with him when he returned to the facility yesterday, he stated no. Resident #2 (R2) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medial record revealed R2 was admitted to the facility [DATE] with diagnoses that included type 2 diabetes, frontotemporal neurocognitive disorder (type of dementia), legal blindness, poly-osteoarthritis (arthritis in five or more joints), diabetic polyneuropathy (weakness, numbness, and pain from nerve damage caused by diabetes), obesity, lymphedema (swelling caused by blocked lymphatic system), tachycardia, bradycardia, chronic kidney disease, and anemia (low red blood cells). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], demonstrated a Bried Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. During an interview on [DATE] at 9:55 AM, R2 was sitting by himself in the hallway doing nothing. R2 stated he didn't have anything to do. Writer asked if he went to any of the activities and he stated, When they tell me about them. Writer asked R2 if anyone took him down to the activity area to watch movies, listen to music or attend a cooking class, he stated no. During an interview on [DATE] at 10:09 AM, Activity Director (AD) N stated she was going to have an activity at 10:00 AM, but nobody showed up. AD N stated she made three one-on-one visits with residents that do not come out of their rooms. Writer asked AD N how she tracks or documents who she had seen or who participated in planned activities, she stated she didn't. During an observation on [DATE] at 10:24 AM, AD N was seen sitting at a table coloring with two residents. During an interview on [DATE] at 11:19 AM, Nursing Home Administrator (NHA) A stated the activities computer crashed and they do not have an October calendar, writer looked in the plan of corrections for activities and they did not include an October calendar in it. NHA A stated she could give surveyors a November calendar. Writer asked for the updated activity calendar and activity involvement record for R2. NHA A stated she can give surveyors a November Calendar but not an October one. Record review revealed R2 did not have a care plan for activities but had a care plan of historical information and activities were mixed in that. Record review also reflected that R2 had an Activities Preferences Assessment completed on [DATE] by Social Worker D. During an interview on [DATE] at 9:15 AM, SW D stated she was just helping get the Activities Preference Assessment completed as they were behind. SW D stated the form gets scanned into the resident's medical record, adding she didn't know what the process is after that. SW D added that she was under the assumption that it went back to the activities Director. During an interview on [DATE] at 9:45 AM, AD N stated she started at the facility as an Activity Director about a month ago. AD N stated she did not have any experience as an Activity Director nor an Activity Aide. AD N also started she had just started the Activity Director Training on [DATE]. AD N stated she had not been involved in care planning for activities, and the MDS coordinator F was helping her. AD N stated she was now scheduling activities on the calendar around resident's preferences. Writer asked AD N what she knew about the Activities Preference Assessment, she stated it told her residents likes and dislikes, and she could gauge what the preferences were. AD N stated if the resident didn't like to come out of their room it is her responsibility to do one-on-one visits with them. AD N stated she did not do anything with R2's care plan but thought she may have (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed it. Record review revealed R2 only attended one of two activities since [DATE]. Activities Preferences Assessment completed on [DATE] showing R2 enjoys cooking, movies, music and listening to the radio. Cooking is the only structured activity, where movies and music are self-directed activities that he doesn't need assistance to do. Activity Director N could not provide an activity calendar for [DATE] to show what activities R2 attended. According to the Activities Charting Report for R2, he attended the Halloween Party on [DATE] but not the resident council meeting on [DATE]. This report did not reflect R2 attending any of his preferred activities. Cooking was on the November Activity Calendar for [DATE] and R2 was not in attendance. No documentation to support if the resident was asked to participate or not. Resident #102-1 (R102-1) Review of the medical record reflected that R102-1 was admitted to the facility on [DATE], hospitalized on [DATE] and was readmitted to the facility on [DATE]. Diagnoses of Congestive Heart Failure, Dysphagia, need personal assistance, high blood pressure and facility acquired stage 3 pressure ulcer to the coccyx. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] revealed R102-1 had a Brief Interview of Mental Status (BIMS) of 04 (Severe Impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R102-1 is dependent on all care. During an observation on [DATE] at 10:30 AM, R102-1 sleeping in her bed with her head covered with a sheet. Bed was in lowest position with fall mat on the floor. No low air loss mattress on her bed. No heal protective boots on her feet. During a record review, R102-1 was care planned to be repositioned every two-three hours, no documentation to support this task was completed. R102-1 had a physician's order to check the low air loss mattress every shift. Physician orders for wound care for R102's facility acquired pressure ulcers read; Special Instructions: Cleanse open area with wound cleanser, pat dry, apply skin prep to peri-wound, apply Medi-honey, hydrogel and collagen to wound bed. Cover with foam border dressing. Change daily and as needed if dressing becomes soiled or dislodged, dated [DATE]. During an observation on [DATE] at 10:45 AM, Licensed Practical Nurse (LPN) H removed the soiled brief, while Doctor E measured the stage 3 pressure ulcer with a disposable tape measure and a sterile Q-tip. Doctor E read off the measurements, washed his hands and left the room. LPN H covered the pressure ulcer on the coccyx with a dry dressing and stated they were using collagen, hydrogel and a foam dressing. The wound was not cleaned with wound wash per the physicians' orders. Skin prep was not applied to the peri-wound per the physician's order. Medi-honey was not applied to the wound bed per the physician's orders. Record review revealed staff were documenting that they checked the low air loss mattress every shift. During an interview on [DATE] at 12:55 PM Assistant Director of Nursing (ADON) G was asked her if R102-1 had a low air loss mattress. ADON G was looking at her computer and stated there were orders to check the function of the low air loss mattress every shift and she could see that was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed. Writer asked ADON G if R102-1 was care planned for the low air loss mattress. Writer walked into room Rm102-1 with the ADON G, ADON G looked over the bed and stated it was a regular mattress. ADON G then stated there would be a low air loss mattress on it today. During an interview on [DATE] at 1:10 PM, LPN H stated she had become the wound care nurse about a month ago and was not certified. LPN H was asked about the staging of this pressure ulcer and LPN H stated she didn't stage it, the doctor staged it. LPN H also stated nurses can not stage wounds, only providers can. Writer asked if R102-1 wound care orders were still active and LPN H stated yes, they were still following the orders from [DATE]. During an interview on [DATE] at 1:20 PM, DON B was asked if R102-1 had a low air loss mattress on her bed. DON B looking at his computer then stated, per the physician orders, one was ordered on [DATE]. DON B then stated R102-1 was on whatever mattress she was on when this started. DON B stated yes, under reports, staff documents that they were checking the function of the low air loss mattress, that did not exist. Writer asked DON B if R102-1 was being repositioned every 2-3 hours as ordered, and care planned. DON B stated there isn't any documentation to support that. Writer asked DON B what the current physicians order was for dressing changes to the pressure ulcer. DON B stated the last physicians dated [DATE] read, Special Instructions: Cleanse open area with wound cleanser, pat dry, apply skin prep to peri-wound, apply Medi-honey, hydrogel and collagen to wound bed. Cover with foam border dressing. Change daily and as needed if dressing becomes soiled or dislodged. Writer asked the DON B if he was aware they were out of Medi-honey and did not use it today during the dressing change. Writer asked DON B if he had any idea how long they had been out of Medi-honey? DON B stated he did not know. Writer asked DON B if this stage 3 pressure ulcer to the coccyx was unavoidable? DON B stated he didn't know. During an interview on [DATE] at 1:50 PM, Regional Clinical Director K stated she had been assisting clinically with the audits, education and in areas of need. Writer asked if she had been informed of the completion of dressing change that took place for R102-1. Writer continued to inform her that it was without the use of Medi-honey to the wound bed, no low air loss mattress was put in place following the physicians order for it on [DATE], and there was not an unavoidable assessment completed on R102-1. During an interview on [DATE] at 2:15 PN, DON B stated he was not sure if a root cause analysis was ever completed for the facility acquired stage 3 pressure ulcer for R102-1. DON B then stated R102-1 was a chronic wound that heals some and then gets bad again. DON B stated he would look for the unavoidable assessment, R102-1 did not admit with this pressure ulcer, stated he was looking under the skin tab in her medical records, continued looking for previous unavoidable assessment, couldn't find one. DON B was asked if the staff reposition R102-1 every 2-3 hours as ordered, and care planned. DON B stated he assumed so since it wasn't getting any worse, but no documentation to support this was done. DON B then stated that he would complete a root cause analysis and unavoidable assessment. Writer than asked if R102-1 had new physician orders for wound care as the facility did not have any Medi-honey. DON B stated he would put in new orders to reflect not using Medi-honey. Record review of physician orders revealed an order for wound care; Coccyx. Special Instructions: Cleanse open area with wound cleanser, pat dry, apply skin prep to peri-wound, apply hydrogel and collagen to wound bed. Cover with foam border dressing. Change daily and prn if dressing becomes soiled or dislodged, dated [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The lack of documentation to support repositioning was completed every 2-3 hours and the lack of use of the protection boots on her feet to prevent further skin breakdown did not aid in wound healing and could have delayed it. Not following physician's orders for replacing the mattress with a low air loss mattress could have delayed healing all together. Not following the physician's orders for wound care is not following professional standards and can delay the healing of the facility acquired stage 3 pressure ulcer to her coccyx. During an observation on [DATE] at 8:00 AM in the only Medication Room in this facility, expired wound care supplies were found mixed in with non-expired wound care supplies being used daily. 1)Aqua-Derm Hydrogel Sheet Wound Dressing, with an expiration date of [DATE]. 2) Hydrocolloid thin dressing, 2 separate dressings expired over a year ago on 07/2024. 3) Hydra-Lock SA, super-absorbent wound dressing with gelling core and waterproof backing was expired for use on [DATE]. During this same observation and interview, LPN/wound care nurse H stated she tried her best to go through all of the supplies and medications in the medication room. No back up plan for who was responsible to assist her to ensure that expired dressing supplies were not being used was identified. During an interview on [DATE] at 9:05 AM, DON B was informed of the expired wound care supplies and said dressings were given to him to dispose of. Resident #13 (R13) Review of the medical record revealed R13 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included: Quadriplegia, vascular dementia, Aphasia, and Cognitive social or emotional deficit following nontraumatic subarachnoid hemorrhage (leaking of blood into the space surrounding the brain). The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R13 scored 4 out of 15 (indicating severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R13's medical record revealed a document titled DO-NOT-RESUSCITATE ORDER had been initiated on [DATE]. The same document revealed no signatures or dates on the two lines for Witness Signature and Date. Review of Element 2 of the Plan of Correction for F578 (Advanced Directives) revealed All residents in the facility are at risk of the deficient practice. The Social Service Director/Designee will audit the advanced directives for all residents in the facility to ensure they are completed and accurate as per the resident/Representative wishes and to ensure the most recent advance directive wishes are in the electronic medical record and in the binders at the nurses' stations. Further review of Element two revealed an audit tool titled Initial Audit Advance Directives with a column labeled Advance Directive completed accurately and thoroughly as per Resident and or Representative's wishes. Yes/No was documented as Yes for all residents included on the initial audit (including R13). The above listed audit tool was dated as being completed on [DATE]. It should be noted the signature line for the audit tool was left blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 3:07 PM Social Worker (SW) D explained that the audit of Advanced Directives (for completion and accuracy) was completed by herself and nursing, which she further explained to include unit managers, DON and ADON. When asked to review the Advanced Directive for R13, SW D, agreed that it should have 2 witness signatures and that should have been caught in the audit conducted by the facility according to their Plan of Correction. In an interview on [DATE] at 1:59 PM, NHA reported she had completed random/spot checks from the names on the audit tool but offered no explanation why R13's Advanced Directive did not have the required witness signatures. Resident #100-1 (R100-1) Review of the medical record revealed R100-1 was admitted to the facility [DATE] with diagnoses that included urinary tract infection, muscle weakness, acute pulmonary edema, anemia, type 2 diabetes, multiple fractures of ribs left side, moderate protein-calorie malnutrition, chronic kidney disease, and metabolic encephalopathy. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R100-1 had a Brief Interview for Mental Status (BIMS) of 10 (moderate cognitive impairment) out of 15. Review of R100-1 medical record revealed a document entitled DO-NOT-RESUSCITATE ORDER had been initiated on [DATE]. The same document revealed R100-1 did not sign but gave verbal consent on [DATE]. The same document revealed first witness signature and date line that had been signed and dated [DATE]. The second witness signature and date line was also the signature of the person who signed the first line and no date was present. The first line that stated type or print witness's name – contained a printed name of a different witness. The second line that stated type or print witness name-contained a signature of the second person. During the review of facility quality audit tool entitled Advance Directives/CPR revealed a column that stated Advance Directive completed accurately and thoroughly as per Resident and or Representative's wishes. Yes/No was documented as Yes. The above listed audit tool was completed on [DATE]. In an interview on [DATE] at 11:47 a.m. Nursing Home Administrator (NHA) A explained that when residents are admitted to the facility the Nurses will ask the residents if they would like to formulate an Advance Directive. NHA A explained that if the resident wishes to formulate an Advance Directive and expresses the wishes of Do not Resuscitate (DNR) the nurses would assist the resident to complete the document entitled Do-NO-RESUSCITATE ORDER. Once the document is completed, they are given to the Social Worker who would make sure the document is correct. NHA A was asked to review R100-1 document DO-NOT RESUSCITATE ORDER for accuracy. NHA A explained that the person that completed the signature lines where not completed correctly and a date was not present of the second signature. NHA A was asked to review the quality audit tool entitled Advance Directives/CPR, which was dated [DATE]. NHA A confirmed that the above document contained R100-1 name. When NHA A was asked if the document had been completed accurately. NHA A stated that is had not been completed accurately because the DO-NOT RSUSCIATE ORDER had not include the date that the document was signed. Resident #103-1 (R103-1) Review of the medical record revealed R103-1 was admitted [DATE] with diagnoses that included (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic obstructive pulmonary disease, muscle spasm, cervicalgia (neck pain), insomnia, prediabetes, gastro-esophageal reflux disease, constipation, left artificial hip, pulmonary heart disease, obstructive sleep apnea, aortic valve disorder, hypertension, hypothyroidism, osteoarthritis, venous insufficiency, and hyperlipidemia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R100-1 had a Brief Interview for Mental Status (BIMS) of 6 (severe cognitive impairment) out of 15. Review of R103-1's medical record revealed that she recently had been discharged to the hospital on [DATE] and had returned [DATE]. Review of the medial record did not reveal that the facility bed hold policy had been provided to R103-1 at the time of discharge In an interview on [DATE] at 04:03 p.m. Director of Nursing (DON) B explained that it was facility policy that residents are given a Bed Hold Policy Acknowledgement by the nursing staff at the time of discharge. DON B explained that once the document is signed a copy is placed in the medical record. DON B was asked to provide a copy of the Bed Hold Policy Acknowledgment form for R103-1's discharge on [DATE]. DON B explain that the document was not in R103-1 medical record and that he would inquire with the person in charge of medical records. Review of the facility Quality Assurance Audits entitled Discharge Notices and Bed hold Notices did not list R103-1 for the audits completed [DATE]. In an interview on [DATE] at 08:34 a.m. Director of Nursing (DON) B explained that a signed bed hold policy was not found for R103-1's discharge on [DATE]. DON B explained that he had been on call for that date and staff should have called and reported the discharge to him. DON B explained at that time he would have made sure that it was completed. DON B also explained that R103-1 had not been included on the Quality Improvement Audits because he was not aware that she had been discharged on [DATE]. DON B explained that a discharged report should have been completed to identify the discharges that are necessary for the audits, however; he could not validate that one had been completed. On [DATE] at 03:13 p.m., observation of the Forest Unit water pass station found that the cooler containing ice for hydration pass was not fitted with the means to self-drain, allowing the ice for consumption to comingle with the melted ice water in the cooler. On [DATE] at 03:14 p.m., observation of the [NAME] North Unit water pass station found the cooler containing ice for hydration pass was not fitted with the means to self-drain, allowing the ice for consumption to comingle with the melted ice water in the cooler. In an interview on [DATE] at 03:18 p.m. Nursing Home Administrator (NHA) A explained that she had been made aware recently that the two blue coolers used for hydration pass could not be fixed because the parts were not available. NHA A could not explain how the facility had alleged compliance with the statement: The Forest Unit water station and the [NAME] Unit water station were fixed so that they self-drain when there was no evidence to support the statement. Of note facility alleged compliance with this issue as of [DATE]. In an interview on 11//18/2025 at 03:27 p.m. Maintenance Director M explained that he could not obtain the necessary parts to fix the Forest Unit water pass station cooler or the [NAME] North Unit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water pass station cooler. Maintenance Director M could not explain why the Forest Unit water pass station cooler and the [NAME] North Unit water pass station cooler were still being used even though they had not been fixed. Maintenance Director M explained that he had ordered different ice coolers that would self-drain. Maintenance Director M could not provide a date that the coolers were ordered and could not provide documentation of the order. On [DATE] at 1:50 PM during a review of the facility's Quality Assurance program, specifically related to the plan of correction with Nursing Home Administrator A, it was reported that each department head was responsible for their own audits. For example, since Social Worker D was responsible for Advanced Directives (F578), Social Worker D was then responsible for completing the audit tool and making corrections as needed. When NHA A was queried who was responsible for ensuring the audits were not just being completed, but being completed with accuracy, NHA A stated she was ultimately responsible. NHA A offered no explanation and failed to provide documentation why several audits were not completed. Review of the facility policy dated 11/2022 titled Quality Assurance and Performance Improvement (QAPI) The QAPI plan will address the following elements:a. Design and scope of the facility's QAPI program and QAA Committee responsibilities and actions.b. Policies and procedures for feedback, data collection systems, and monitoring.c. Process addressing how the committee will conduct activities necessary to identify and correctquality deficiencies. Key components of this process include, but are not limited to, the following:i. Tracking and measuring performance.ii. Establishing goals and thresholds for performance improvements.iii. Identifying and prioritizing quality deficiencies.iv. Systematically analyzing underlying causes of systemic quality deficiencies.v. Developing and implementing corrective action or performance improvement activities.vi. Monitoring and evaluating the effectiveness of corrective action/performance improvementactivities and revising as needed.d. A prioritization of program activities that focus on resident safety, health outcomes, autonomy,choice and quality of care, as well as, high-risk, high-volume, or problem-prone areas as identifiedin the facility assessment that reflects the specific units, programs, departments and uniquepopulation the facility serves. The facility must also consider the incidence, prevalence, andseverity of problems or potential problems identified.e. A commitment to quality assessment and performance improvement by the governing body and/orexecutive leaders.f. Process to ensure care and services delivered meet accepted standards of quality.4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program.Documentation may include, but is not limited to:a. The written QAPI plan.b. Systems and reports demonstrating systematic identification, reporting, investigation, analysis, andprevention of adverse events.c. Data collection and analysis at regular intervals.d. Documentation demonstrating the development, implementation, and evaluation of correctiveactions or performance improvement activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living. Findings Include:On 9/2/25 at 1:44 PM, observation of the Forest Unit spa room found three call lights in the room, two of the call lights had pull cords 18 to 28 inches off the ground and the third call light (in the far shower) did not have a pull cord at all. Further observation of the spa room found a nickel sized sticker on the shower wall with an image of a snowflake and three clean washcloths open and exposed on the rack in the first shower stall. On 9/2/25 at 1:58 PM, observation of the [NAME] Unit soiled utility room, found two boxes of gloves and two rolls of trash bags in the hand sink. Further observation found that the atmospheric vacuum breaker (AVB), in the over hopper faucet, was found to be leaking heavily when the faucet was turned on. On 9/2/25 at 2:00 PM, observation of the [NAME] South spa room, found that the call light in the far shower did not have a pull cord and the call light near the commode did not activate the call light upon first pull. Further review of the spa found the shower bed with increased accumulation of debris on the shower mat as well as dark brown staining and dirt accumulation underneath the mat surface. On 9/3/25 at 9:07 AM, with Maintenance Director (MD) AA, observation of the Forest Unit spa room found the nickel sized snowflake sticker on the shower wall and the three washcloths stored on the rack outside the first shower stall. An interview with MD AA found that Certified Nursing Assistants (CNA's) should clean up between residents and that housekeeping staff will come in daily to tidy up and clean the room. On 9/3/25 at 9:18 AM, with MD AA, observation of resident room [ROOM NUMBER] found that there was no pull cord for the bathroom call light. Further observation found that no audible noise or visual display of suction was found on the exhaust ventilation of the bathroom (tested with paper towel). On 9/3/25 at 9:22 AM, observation of the Forest Unit janitors closet found that the faucets internal AVB was leaking when the water was turned on. On 9/3/25 at 9:40 AM, observation of the Laundry room found one of the main light fixtures did not have a shield to protect the lights from breaking. On 9/3/25 at 10:05 AM, observation of the central supply room found an odor of sewer gas. Further review found an open and uncovered floor drain in the back of the supply room with a slight flow of air coming from the drain. On 9/3/25 at 10:17 AM, observation of the Oxygen storage room, accessed from outside of the facility, was found to have an outer opening under the access door. Visual light was able to be seen under the bottom of the door with a 1/4 inch gap for pests to enter. On 9/3/25 at 10:25 AM, observation of the [NAME] North spa room found clothes and towels set up for the next resident. At this time a large amount of hair was found in the shower drain. On 9/3/25 at 10:32 AM, observation of the [NAME] South clean utility room found eight packages of briefs stored on the floor under shelving. On 9/3/25 at 10:42 AM, observation of the [NAME] South spa room found the call lights and the shower bed in the same condition as the previous day's observation. On 9/3/25 at 10:45 AM, observation of the [NAME] janitors closet found that the internal AVB of the faucet leaked when turned on. On 9/3/25 at 10:49 AM, observation of the [NAME] soiled utility room found two boxes of gloves and two rolls of trash bags in the hand sink. On 9/3/25 at 10:52 AM, observation of the AC inverter on the wall of the [NAME] South unit, was found with increased accumulation of black spotted debris on the inside fan mechanism of the unit. On 9/3/25 at 10:56 AM, observation of resident room [ROOM NUMBER] found no audible or visual display of suction on the exhaust ventilation of the bathroom (tested with paper towel). When asked if he had been on the roof to check exhaust ventilation recently, MD AA stated he had not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to honor a resident's/guardian (#4) Advance Directives (a written statement of a resident's wishes regrading medical treatment) for DNR (Do not Resuscitate) of one residents reviewed. Findings Include:Resident #4(R4) Review of the medical record revealed R4 was admitted to the facility [DATE] with diagnoses that included cerebral palsy (a group of disorders that affect movement, muscle tone, and posture due to damage to the developing brain), hypertension, hyperlipidemia (high fat content in blood), epilepsy, contracture right elbow, contracture left elbow, contracture right hand, contracture left hand, gastro-esophageal reflux disease, dysphagia (difficulty swallowing), cognitive communication deficit, contracture right lower leg, contracture left lower leg, contracture right knee, contracture left knee, contracture right ankle, contracture left ankle, aphasia (language disorder that affects person's ability to speak) , anemia (low red blood cells), neuromuscular dysfunction of bladder (disorder affecting ability to store and release urine), chronic respiratory failure with hypoxia, tracheostomy status, (surgical opening in the windpipe to provide an airway and facilitate breathing) and gastrostomy status (opening in the stomach through the abdominal wall to provide nutrition and medication). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed that a Brief Interview for Mental Status (BIMS) could not be performed because R4 was rarely/never understood. On [DATE] at 09:59 a.m. during observation and attempted interview R4 was observed lying down in bed and appeared well groomed. R4 failed to respond to verbal questions. Review of R4's medical record banner, located on the top of her computerized medical record, revealed R4 was listed as a Full Code (wishes to have cardiopulmonary resuscitation performed if her heart or breathing were to be found absent). Review of her most recent physician order, dated [DATE], revealed Code Status: Full Code. Give CPR. Review of R4's plan of care revealed Resident (guardian) has participated in Advance Care Planning and has made these wishes known if in the future they are no longer able to do so. Refer to Advance Directive tab under Resident Documents for most recent medical treatment decisions To carry out resident's wishes for a full code and to contact family and guardian for any other needs. Review of R4's scanned documents in her medical record revealed Michigan Do-Not-Resuscitate Order , dated [DATE], which was signed by R4's Legal Guardian.Review of R4's medial record revealed a progress note, dated [DATE], stated (name of physician) is aware of code status change to full code.In an interview on [DATE] at 12;29 a.m. Social Worker (SW) L explained that R4's guardian had requested a Michigan Do-Not-Resuscitate Order on [DATE]. SW L explained that R4's then had an order that she was to be a DNR. SW L explained that the previous Nursing Home Administrator had told her that a Guardian could not determine a resident's code status in the state of Michigan. SW L explained that she had spoken with R4's guardian at that time and the order for Do-Not-Resuscitate Order was rescinded. SW L was asked to provide information from the medical record demonstrating the conversation with the guardian and information recorded of those wishes. SW L was unable to provide any information from the medical record.Review of MCL-Section 700.5314 revealed, The power of a guardian to execute a do-not-resuscitate order under subdivision (d), execute a nonopioid directive form under subdivision (f), or execute a physician orders for scope of treatment form under subdivision (g) does not affect or limit the power of a guardian to consent to a physician's order to withhold resuscitative measures in a hospital. As used in this subdivision, involuntary mental health treatment means that term as defined in section 400 of the mental health code, 1974 PA 258, MCL 330.1400. (d) The power to execute, reaffirm, and revoke a do-not-resuscitate order on behalf of a ward. However, a guardian shall not execute a do-not-resuscitate order unless the guardian does all of the following: (i) Not more than 14 days before executing the do-not-resuscitate order, visits the ward and, if meaningful communication is (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible, consults with the ward about executing the do-not-resuscitate order. (ii) Consults directly with the ward's attending physician as to the specific medical indications that warrant the do-not-resuscitate order. (e) If a guardian executes a do-not-resuscitate order under subdivision (d), not less than annually after the do-not-resuscitate order is first executed, the duty to do all of the following: (i) Visit the ward and, if meaningful communication is possible, consult with the ward about reaffirming the do-not-resuscitate order. (ii) Consult directly with the ward's attending physician as to specific medical indications that may warrant reaffirming the do-not-resuscitate order. (f) The power to execute, reaffirm, and revoke a nonopioid directive form on behalf of a ward.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 - Few	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 and/or resident's representative of the facility policy for bed hold and a written reason for the transfer, for one (Resident #50) and failed to provide notice of discharges and transfers, to the representative of the Office of the State Long-Term Care Ombudsman for two of two residents reviewed (Resident #50 and #52).Findings include: Resident #50 Review of the clinical record revealed R50 was admitted to the facility on [DATE] with a diagnosis of chronic kidney failure and heart failure. Further review of the clinical record revealed R50 was transferred to the hospital on [DATE] and did not return to the facility. There was no documentation in the clinical record to reflect R50 or his representative was provided in writing in a language they would understand explaining the reason for the transfer, no documentation that bed hold information was provided. Resident 52Review of the clinical record for Resident #52 (R52) revealed an admission date of 7/16/2025 and a discharged home against medical advice on 7/18/2025. On 09/06/2025 at 1:36 pm, during an interview with Regional Clinical Director O reported she was aware bed hold policy, transfer notification in writing was not being done and they had issues with concerns with the facility transfer/ discharge process. A request for documentation of the discharge/transfer log that was to be sent to the Ombudsman for the month of July 2025 was requested at that time. On 09/08/2025 9:17 AM a second request for the July 2025 discharge/transfer log the facility sends to the Ombudsman was requested. At 12:36 PM, Nursing Home Administrator (NHA) A reported they had contacted the former NHA and that the long-term Care Ombudsman office had not been notified of any discharges/transfers in July of 2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to submit a significant change Minimum Data Set (MDS) for one (Resident #13) out of 12 reviewed for significant change MDS. Findings include: Review of the medical record reflected Resident #13 (R13) was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Aphasia, Pressure ulcer of right hip, pressure ulcer of left hip, vascular dementia, Quadriplegia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/27/2025, reflected R13 scored 4 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 9/02/2025 at 1:46 PM, R13 was observed in bed sleeping. R13 did not respond to an interview request. Review of a Progress Note dated 03/12/2025 at 12:39 AM reflected resident [R13] left hip has open area on his old wound . Review of the Physician Orders revealed an order for wound care for R13's left hip was not ordered and implemented until 4/5/25. Review of a Progress note dated 04/05/2025 at 12:04 PM reflected Old surgical wound on left hip has opened up. Treatment in place, wound doctor will evaluate this week . Further documentation revealed that R13's left hip open area was classified as a Stage 3 Pressure ulcer (full-thickness skin loss). In an interview on 9/8/25 at 9:04 AM, MDS Coordinator G confirmed that a significant change MDS was not completed upon the discovery of R13's Stage 3 pressure wounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for one resident (#25) of 12 residents reviewed for accurate assessments. Findings Included:Resident #25 (R25) Review of the medical record revealed R25 was admitted to the facility 08/27/2016 with diagnoses that included Parkinsonism (a group of neurological disorders that share similar symptoms to Parkinson's disease), seizures, disorders of psychological development, type 2 diabetes, anemia (low red blood cells), anxiety, bipolar disorder, hypothyroidism (low thyroid hormone), peripheral vascular disease (PVD), gastro-esophageal reflux disease, constipation, Parkinson's disease, malnutrition, dementia, and dysphagia (difficulty swallowing). Review of R25's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/18/2025 revealed a Brief Interview for Mental Status (BIMS) of 00 (severe impaired cognition) out of 15. On 09/02/2025 at 10:14 a.m. during observation and attempted interview R25 was observed sitting up in the hallway, in his wheelchair. R25 appeared well groomed. R25 responded to questions but was not understandable. Review of R25's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/18/2025, section K-Swallowing/Nutritional Status- K0300 Weight loss - Loss of 5% or more in the last month or loss of 10% more in the last 6 months was coded as yes. Review of progress note 03/20/2025 12:08 PM Current wt. of 109.2lbs BMI 17 reflects a wt loss of 17lbs (13.6%) x 32 days. Diet is Puree with Honey thick liquids, small spoons only (No forks or knives), food in bowls; magic cup 1 carton TID to provide an additional 870kcals and 18g or protein. Allergies to Chocolate, Red Dye found in foods, Strawberries. Po intake is 75-100% of meals and 75-100% of supplements. Diuretic, thyroid and antidepressant therapy in place.In an interview on 09/05/2025 at 09:19 a.m. Registered Dietician (RD) N explained that she had entered the note, listed above on 03/20/2025. RD N explained that she had also coded section K of the MDS with and ARD of 03/18/2025. When asked if there was a follow up progress note because of the weight loss RD N explained that there was not follow up to the weight loss because that information was found not to be an accurate weight. RD N explained that the reviewing the weight loss variance report did not demonstrate that R25 had in fact had a weight loss. RD N explained that she coded the MDS incorrectly and should have corrected the data entry as R25 not having a weight loss.Review of R25's document (provided by facility) entitled Weight Variance Report, dated 01/01/2025, revealed R25 did not have weight loss of greater than 3.5% during that period of time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure showers were provided on a routine, regularly scheduled basis and as preferred for one resident, (Resident #6) of one reviewed.Findings include:Review of the clinical record, including the Minimum Data Set, dated [DATE] revealed Resident #6 (R6) was admitted to the facility with diagnoses that included major depression, obesity and dementia. R6 scored 12 out of 15 (moderated cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 09/02/2025 at 10:10 AM, during an interview with R6 reported being displeased about not getting showers twice a week. R6 stated she was supposed to receive showers on the afternoon shift, but this does not happen consistently. Review of the R6's clinical record revealed R6 received 3 showers in April, (4/8, 4/15 and 4/29) 3 showers in May 2025 (5/2, 5/16, 5/27), 3 showers in June 2025 (6/3, 6/17, 6/20) and 5 in July (7/16, 7/18, 7/22, 7/25, 7/29). There was no evidence in the clinical record that R6 refused care any showers. R6's activity of daily living care plan dated 6/3/24 revealed R6 would receive showers twice a week on the afternoon shift. On 09/04/2025 at 10:43 AM, during an interview with Certified Nursing Assistant (CNA) Y reported being very familiar with R6, CNA Y reported she never refuses care, when quired about showers, CNA Y reported R6 had her showers on the afternoon shift and R6 will occasionally complain about not getting a shower the night the before and will request day shift to give her a shower. On 09/04/2025 at 10:58, during an interview with License Practical Nurse/Unit Manager C reported R6 was compliant with care and showers but was new to the Unit Manager position and didn't realize she was not getting showers routinely. On 09/04/2025 at 11:33 AM, during an interview with Interim Director of Nursing (DON) H reported she was an interim DON and recently implemented shower documentation to be tracked on the treatment record in order to track and monitor showers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 - Few	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 interview and record review, the facility failed to initiate Cardiopulmonary Resuscitation efforts in a timely manner for one (Resident #51) of one reviewed. Findings include: Review of the medical record reflected R51 was admitted to the facility on [DATE], with diagnoses that included Chronic obstructive pulmonary disease and Respiratory failure. R51 expired at the facility. Review of the Electronic Medical Record revealed a Physician Order dated [DATE] which stated Full Code, Give CPR (Cardiopulmonary resuscitation). Review of R51's Electronic Medical Record reflected R51 expired at the facility, however, there was no documentation to describe the events that surrounded R51's change in condition and passing. In an interview on [DATE] at 2:23 PM, Licensed Practical Nurse (LPN) E confirmed she was working the night R51 had experienced a change in condition. LPN E reported that she was alerted to R51's condition when a staff member notified her that R51 was on the floor, positioned on his stomach. LPN E reported that she observed R61 on the floor of his room and he appeared purplish. LPN E stepped out and called for help, which prompted response from other staff members, including Registered Nurse (RN) J. LPN E then exited the room to confirm R51's code status, however, what is normally described as a quick process was met with delays when LPN E could not readily locate R51's most recent Advanced Directive which is typically located in the Code Status binder at the nurses station. LPN E stated she located R51's Advance Directive from his prior admission earlier that year which stated R51 was a Full Code. LPN E confirmed that attempting to locate the document and making phone calls took about 4 to 5 minutes. Upon return to R51's room, the present staff had no initiated CPR, so LPN E positioned R51 onto his back and initiated CPR. In an interview on [DATE] at 8:30 AM, RN J confirmed that she was working the night that R51 had experienced a change in condition. RN J stated that she waited in the room while LPN E was gone checking for R51's code status. RN J confirmed that CPR was not initiated until LPN E returned to the room. On [DATE] at 10:33 AM, Social Work L confirmed that Adanced Directives are updated upon admission to the facility and placed in the Code Status binder that is kept at the nurse's station. In an interview on [DATE] at 9:25 AM, Regional Clinical Director (RCD) O stated that the process for initiating CPR would be to initiate chest compressions immediately. RCD O verified that typically Advanced Directives are kept at the nurse's station in the Code Status Binder, however, R51's most recent Advanced Directive was not readily available in the binder which led to a delay in the initiation of CPR. According to the Basic Life Saving manual provided by the American Heart Association, chest compressions must be initiated no longer than 10 seconds after finding someone pulseless.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement pressure wound treatment orders in a timely manner for one (Resident #13) out of one reviewed for pressure wounds. Findings include: Review of the medical record reflected Resident #13 (R13) was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Aphasia, Pressure ulcer of right hip, pressure ulcer of left hip, vascular dementia, Quadriplegia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/27/2025, reflected R13 scored 4 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 9/02/2025 at 1:46 PM, R13 was observed in bed sleeping. R13 did not respond to an interview request. Review of a Progress Note dated 03/12/2025 at 12:39 AM reflected resident [R13] left hip has open area on his old wound . Review of the Physician Orders revealed an order for wound care for R13's left hip was not ordered and implemented until 4/5/25. Review of a Progress note dated 04/05/2025 at 12:04 PM reflected Old surgical wound on left hip has opened up. Treatment in place, wound doctor will evaluate this week . Further documentation revealed that R13's left hip open area was classified as a Stage 3 Pressure ulcer (full-thickness skin loss). On 9/04/2025 at 11:09 AM, Regional Clinical Director (RCD) O stated that the facility had completed a Past Noncompliance for pressure ulcers after identification of a delay in treatment for pressure ulcers. RCD confirmed that there was a delay in treatment orders for R13 which was a reason the facility initiated a PNC. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included a skin assessment on all residents, a facility wide audit on care places, Physician orders, and wound documentation, policy and procedure review, weekly audits for wounds and treatment orders, and facility wide education. The facility was able to demonstrate monitoring of the corrective action and maintained compliance with a correction date of 7-31-25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to label medication with open dates in two of three medication carts reviewed and failed to record refrigerator temperatures for two or two medication refrigerators reviewed. Finding Included:On 09/08/2025 at 10:04 a.m. during inspection of [NAME] North medication cart, with Licensed Practical Nurse (LPN) W, it was observed that the following medication was open and did not have a date that they were opened recorded on the medication container: Trelegy 100mcg(micrograms)/62.5mcg/25mcg inhalers, and two Albuterol Sulfate inhalers 90mcg.During an interview on 09/08/2025 at 10:05 a.m. Licensed Practical Nurse (LPN) W explained that it was the facility practice to date all medication once it is open. LPN W could not explain why the identified medication above in [NAME] North medication cart did not have a date on the medication container when it was open. LPN W explained that she would be calling pharmacy to replace the inhalers that were not dated. On 09/08/2025 at 10:11 a.m. Review of [NAME] Medication Room during inspection it was observed to contain three refrigerators. Refrigerator #1 was observed to contain locked controlled medication. Refrigerator #2 was observed to contain mediation delivered from pharmacy that needed to be refrigerated-ie. Vaccinations and insulins. On 09/08/2025 at 10:17 a.m. Unit Manger (UM) C provide the Refrigerator Temperature Logbook which contained the recorded temperatures for refrigerators #1, and #2. The Temperature logs were observed to not be recorded for 09/06/2025 and 09/02/2025. UM C explained that the temperatures are to be record twice per day. UM C could not explain why temperatures were not recorded for those dates. Observation of the current temperatures revealed refrigerator #1 was 36 degrees Fahrenheit and refrigerator #2 was 46 degrees Fahrenheit. On 09/08/2025 at 10:29 a.m. during inspection of [NAME] 2 medication cart, with Licensed Practical Nurse (LPN) X, it was observed that the following medication was open and did not have a date that they were opened recorded on the medication container: Combivent 20mcg (micrograms)/100mcg. LPN X explained that the inhaler should have been dated when opened. LPN X could not explain why the inhaler was not dated. During an interview on 09/08/2025 at 10:39 a.m. Director of Nursing (DON) B explained that it was her expectation and policy that all mediation that was prescribed to residents and provided by pharmacy should be dated at the time that it was opened. DON B also explained that it was her expectation that medication refrigerator temperatures are to be recorded twice per day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review the facility failed to provide dental services for one resident (8) out of one resident's review for dental services. Findings Included:Resident #8(R8) Review of the medical record revealed R8 was admitted to the facility 12/31/2024 with diagnoses that included bipolar disorder, type 2 diabetes, hypertension, hyperlipidemia (high fat content in blood), gastro-esophageal reflux disease, restless leg syndrome, paranoid schizophrenia, chronic pain, anxiety, depression, and obesity. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/07/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on R8 was observed lying in bed. R8 was observed edentulous (without teeth). R8 explained that she had dentures while she was at home but when she came to the facility, she did not have her dentures. R8 explained that she had informed someone that she would like her dentures, but she had not received any recent updates on obtaining dentures for her. Review of R8's medical record did not reveal any documentation of a referral for dental services. Review of R8's plan of care, dated 01/13/2025, revealed a Impaired oral/dental status AEB (as evidence by): no natural teeth or tooth fragments(edentulous). Resident does not have her dentures with her currently. During a telephone interview on 09/05/2025 at 08:49 a.m. R8's sister S explained that R8 had previously had dentures while she as at home. R8's sister S explained that she was found in her apartment unresponsive and was taken to the hospital without her dentures or any clothing. R8's sister S explained that R8's landlord had thrown away all of R8's belongings and that included her dentures. R8's sister S explained that she had talked to someone about obtaining dentures for R8 but could not recall if it was someone at R8s' insurance company or at the facility.In an interview on 09/05/2025 at 10:34 a.m. Social Worker (SW) L explained that when residents were admitted to the facility, residents are offered dental, podiatry, and vision services which are provided by the facility through a third-party provider. SW L explained that once the permission is signed by the resident/responsible person for services, a physician order is obtained, and the resident is scheduled for those services. SW L was could not answer if R8 had requested dental services for dentures. SW L could not locate any information regarding a third-party provider being approved for R8, in the medical record.On 09/05/2025 at 12:55 p.m. Social Worker (SW) L provided a document with consent for dental services which was signed by the resident on 03/19/2025. SW L could not explain if the referral was sent to the third-party provider for dental services. SW L also provided an order by the physician for dental service, signed 12/31/2024. SW L could not explain why R8 had not been included on a list of residents to be seen for dental services after the consent and orders where obtained.On 09/05/2025 at 01:14 p.m. during a telephone interview with the third-party dental receptionist T explained that the facility had not provided any referral document for R8 requesting dental services. Dental receptionist T explained that the facility had notified the third-party dental services today that a dental referral was needed and the dental receptionist T explained that she was currently in the process of obtaining a date of service. Dental receptionist L explained that the third-party dental service provider had last been in the facility 07/29/2025 and R8 had not received dental services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to offer the influenza immunization to one (Resident #13) out of 5 reviewed for immunizations. Findings include:Review of the medical record reflected Resident #13 (R13) was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Aphasia, Pressure ulcer of right hip, pressure ulcer of left hip, vascular dementia, Quadriplegia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/27/2025, reflected R13 scored 4 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 9/02/2025 at 1:46 PM, R13 was observed in bed sleeping. R13 did not respond to an interview request. During immunization record review, there was an absence of any offering of the influenza vaccine for 2024. In years prior, R13 had consented to and received the influenza vaccine. On 9/08/2025 at 12:08 PM, Regional Clinical Director O stated that she was unable to locate any documentation for R13's vaccines for 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to offer the COVID-19 immunization to one (Resident #13) out of 5 reviewed for immunizations. Findings include: Review of the medical record reflected Resident #13 (R13) was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Aphasia, Pressure ulcer of right hip, pressure ulcer of left hip, vascular dementia, Quadriplegia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/27/2025, reflected R13 scored 4 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 9/02/2025 at 1:46 PM, R13 was observed in bed sleeping. R13 did not respond to an interview request. During immunization record review, there was an absence of any offering of the COVID-19 vaccine for 2024. In years prior, R13 had consented to and received the COVID-19 vaccine. On 9/08/2025 at 12:08 PM, Regional Clinical Director O stated that she was unable to locate any documentation for R13's vaccines for 2024.