STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235192	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mymichigan Skilled Nursing Facility	805 West Cedar Standish, MI 48658

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have an active 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 existing and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility. Findings include:On 04/14/2026 at 9:53am observed two spigots on dirty side of laundry room. During this observation, Housekeeping Manager C was interviewed on whether the spigots were used for anything, and she stated they are not used. On 04/14/2026 at 9:55am observed two dead-end lines coming down from the ceiling that are not connected to anything, adjacent to the washers. The unused piping looked identical to the washer hookups. During this observation, Housekeeping Manager C was interviewed on whether the lines were used for anything and stated they haven't used them since she's been working here. On 04/14/2026 at 9:57am observed a dead-end water line with what appears to be a filter attached, near the desk area in the laundry room. During this observation, Housekeeping Manager C was interviewed on whether the water lines were used for anything and she stated it hasn't been used since she's been working here. On 04/14/2026 at 12:12pm interviewed Maintenance Mechanic D on whether the dead-end plumbing in the laundry room is flushed on a regular basis, and he stated the unused water lines hanging from the ceiling adjacent to the washers are flushed monthly, but the two unused spigots on the dirty side and the water line with the filter near the desk area, are not flushed. According to the facility Water System Program and Risk Assessment, under dead legs/abandoned piping, Remove piping and fixtures that are no longer used. Flush dead piping that is not removed.According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Eliminate dead legs, which are sections of no- or low-water flow. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate indications for use of chemical restraints for 5 residents (Residents #4, #11, #12, #17 and #23), of 12 residents reviewed for chemical restraints, resulting in, decreased communication between professional staff, the protentional for unmet resident needs, care not tailored toward residents' needs, and sedation with falls. Findings Include: Review of the facility Behavior Management Monitoring Policy and Procedure last reviewed on 4/2025, stated The Behavioral Management Committee (BMC) shall monitor weekly and more frequently as needed: use of psychoactive medications and for potential to reduce/eliminate psychoactive medications. The BMC will seek to determine if there is justification for the initiation of psychoactive medications. The Social Worker will review the progress notes (nursing notes) and POC (Care Plans) prior to BMC reviews. During an interview done on 4/14/26 at 10:30 a.m., Social Service RN E, stated Our communication for our behaviors is done in our morning meeting; I can't read every nurse's note every day. Having someone on the floor more concentrating on behavioral health (including medications) would help. Social Service E said she was not aware of a Behavioral Management committee and was not familiar with the facility Behavioral Management policy; the way she got her information regarding resident behaviors and justification for psychoactive medications was per nursing notes/progress notes and at the 24-hour meetings. Resident #11: Review of the Face Sheet, nursing notes dated 4/26, physician orders dated 4/26, and care plans dated 4/6/26, revealed Resident #11 was [AGE] years old, alert, admitted to the facility on [DATE], and was dependent on staff for Activities of Daily Living/ADL's. The residents' diagnosis included kidney disease stage 3, spinal stenosis, low back pain, diabetes, chronic lung disease, arthritis, and was dependent on oxygen therapy. Review of the physician order dated 4/3/26, stated Sertraline tablet 50 mg (antidepression medication) once a day DX (diagnosis) depression. Review of the residents' Psychotic Drug Use care plan dated 4/6/26, stated Assess/record effectiveness of drug treatment, monitor and report signs of sedation, attempt non-pharmacological interventions, implement a mood management plan to complement drug therapy, monitor residents' mood and response to medication. Review of the residents' Psychosocial Well-Being care plan dated 4/6/26, stated Assess mood and potential for loneliness, address mood issues such as depression. Review of the residents' nurse's notes (progress notes) dated 4/3/26 through 4/13/26, revealed no entries of resident behaviors, assessing or monitoring of behaviors, no documentation of justification for Sertraline medication. Resident #12: Review of the Face Sheet, nursing notes dated 4/26, physician orders dated 4/26/26, and care plans (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 4/27/26, revealed Resident #12 was [AGE] years old, admitted to the facility on [DATE], alert with confusion, and dependent on staff for ADLs. The residents' diagnosis includes stroke with hemiplegia and hemiparesis, high blood pressure, chronic lung disease, neuromuscular dysfunction of bladder, gastro-esophageal disease, and psychotic disorder with delusions and skin picking. Review of the physician order dated 8/16/24, stated Lexapro tablet 5 mg once a day (anti-depressant medication), review of the physician order for Remeron 15 mg once daily for sleep/mental health (depression medication, not for sleep), and review of physician order dated 3/31/26, stated Buspirone tablet 5 mg (anti-anxiety medication) once a day for anxiety disorder. Review of the residents' Psychotropic Drug Use care plan dated 11/7/25, stated Assess/record effectiveness of drug treatment, monitor and report signs of sedation, attempt non-pharmacological interventions, monitor (Resident #12) mood and response to medication, implement a mood management plan to complement drug therapy. Review of the residents' Behavioral Symptoms care plan dated 8/8/24, stated Divert residents' behavior by providing distraction, addressing needs, observe and report socially inappropriate/disruptive behaviors when around others. Review of the residents' Mood State care plan dated 5/1/23, stated Monitor possible causes of insomnia (depression/anxious thoughts), if mood declines report to doctor for evaluation, and a list of target behaviors with individual interventions documented. Review of the residents' nursing notes dated 3/16/26 through 4/10/26, revealed no documentation of targeted behaviors with interventions, no assessment of behaviors, and no monitoring of behaviors. No justification for his psychoactive medications was found. During an interview done on 4/14/26 at 10:30 a.m., Social Service E said she was unable to find documented justification for his psychoactive medications. Resident #17: Review of the Face Sheet, nursing notes dated 4/26, physician orders dated 12/9/24, and care plans dated 10/1/24, revealed Resident of #17 was [AGE] years old, admitted on [DATE], able to answer questions, and dependent on staff for ADL's. The residents' diagnosis included Dementia, Diabetes, Psychotic disturbance, Mood disturbance and anxiety. Review of the physician order dated 12/9/25, stated Sertraline tablet; 25 mg (depression medication) once a day for major depressive disorder. Review of the physician order dated 12/9/24, stated Aricept 10 mg once a day for dementia, behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Review of the residents' Psychotic Drug Use care plan dated 10/1/24, stated Assess/record effectiveness of drug treatment, monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms, assess if her behavioral symptoms present a danger to the resident and/or others, implement a behavior management plan, monitor residents' behavior and response to medication. Review of the only two Behavior Management Team notes dated 2/10/26 and 4/13/26, revealed no documentation of the residents' behaviors. During an interview done on 4/14/26 at 10:30 a.m., Social Service E said she only found two facility (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Behavior Management Team notes for the resident (on 2/10/26 and 4/13/26). Review of the residents nurses notes/progress notes dated 3/26 through 4/5/26, revealed only two entries of resident swatting at staff, on 4/3/26 and 4/4/26. During an interview done on 4/14/26 at 10:30 a.m., Social Service E said that was all the behaviors that she could find in the nurse's notes (on 4/3/26 and 4/4/26). Social Service E said that was not enough to justify psychoactive medications for this resident. Resident #23: Review of the Face Sheet, nursing notes dated 4/26, physician orders dated 4/26, and care plans dated 4/14/26, revealed Resident #23 was [AGE] years old, alert and able to answer questions, admitted to the facility on [DATE], and dependent on staff for ADL's, mobility, turning and repositioning in bed. The residents' diagnosis included, Cerebral infarction with left sided weakness, occlusion and stenosis of cerebral arteries, Hashimto's (autoimmune thyroiditis disease), generalized anxiety disorder, and high blood pressure. Review of the residents' physician order and Electronic Medication Administration/EMAR dated 4/9/26, revealed the resident had physician orders for Lorazepam .5mg every 6 hours (Ativan, anxiety disorder medication) and Buspirone 5mg three times a day (anxiety disorder medication). Review of the Psychotic Drug Use care plan dated 4/14/26 (survey, 4/13/26 through 4/15/26), stated attempt non-pharmacological interventions, assess for cause/condition of mood disturbance, assess if the residents behavioral/mood symptoms present a danger, implement a mood management plan to complement, monitor for drug use effectiveness, monitor residents' mood and response to medication. Review of nurse's notes from admission to 4/9/26 to 4/14/26, revealed no documentation of behaviors, an implemented mood management plan, or any monitoring of behaviors. During an interview done on 4/14/26 at 10:30 a.m., Social Service E said she was unable to find any documentation for psychoactive medications. Social Service E said she was not aware of a behavioral management program justifying the use of psychoactive medications for resident's. During an interview done on 4/15/26 at 1:16 p.m., the Administrator stated We have some room for improvement. Resident #4: Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses which included dementia and depression. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired, displayed no behaviors, and required maximum to total assistance for dressing and bathing. The MDS assessment detailed the Resident did not have anxiety and/or psychotic disorder. However, a diagnosis code indicating Unspecified dementia, severe, with psychotic disturbance was included. Review of prior MDS assessments revealed the diagnoses code for Unspecified dementia, severe, with psychotic disturbance was not present on Resident #4's MDS assessments until the assessment (continued on next page)

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	235192	A. Building B. Wing	04/15/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated [DATE]. Review of the MDS assessments dated 2/7/25 and 5/6/25 revealed the Resident did not display any behaviors. Review of Resident #4's Health Care Provider (HCP) orders and Medication Administration Record (MAR) revealed the Resident was receiving the following psychotropic medications: - Fluoxetine (Prozac- antidepressant medication) 10 mg daily at bedtime (Start date: 6/6/25). The diagnosis/indication for the medication was listed as depressive episodes. - Buspirone (Buspar – medication used to treat anxiety) 5 milligrams (mg) daily (Start date: 3/30/26). The diagnosis Unspecified dementia, severe, with psychotic disturbance was listed as the indication for the medication use. - Zyprexa (Olanzapine- atypical antipsychotic medication indicated in the treatment of schizophrenia and bipolar disorder) 2.5 mg daily at bedtime (Start date: 10/13/25). The diagnosis/indication for use for Unspecified dementia, unspecified severity, with anxiety. Note: Zyprexa has a black box warning for increased mortality for elderly patients with dementia-related psychosis and is NOT approved for treatment of patients with dementia-related psychosis. Note: Use of Zyprexa and Fluoxetine together also has a Black Box Warning from the FDA which specifies treatment of elderly patients with dementia-related psychosis increase risk of death and the combination of the medications is NOT approved for patients with dementia-related psychosis. An interview was conducted with Social Service Registered Nurse (RN) E and RN F on 4/14/26 at 12:00 PM. When queried, RN E verbalized they monitored psychotropic medication use for residents at the facility. Resident #4's psychotropic medications were reviewed with RN E and RN F at this time. When queried regarding the appropriateness of the indications and diagnoses listed for use of Buspar and Zyprexa, RN E stated that was Not okay. RN F verbalized they were not acceptable diagnoses for the use of the psychotropic medication. When queried regarding consents for Resident #4's psychotropic medications, RN E located and provided copies of the consent documentation. Review of the Consent forms detailed the following: - Informed Consent/Risk Benefit Analysis. Prozac . Reason for use and benefits expected: Anxiety reduction, reduced crying . The form was signed by Resident #4's Durable Power of Attorney (DPOA) and RN I RN G on 3/11/25. - Informed Consent/Risk Benefit Analysis. Zyprexa. Reason for use and benefits expected: dementia with psychosis and paranoia, decrease paranoia, anxiousness. Signed by RN G on 3/11/25 and RN H on 3/12/26. On the Resident/Representative signature line, verbal notification/consent provided by (Resident #4's DPOA) was written with the date 3/11/25. - Informed Consent/Risk Benefit Analysis. Buspar . Reason for use and benefits expected: decrease anxiety. The form was signed by RN G on 10/25/24 and indicated verbal consent via phone was obtained via phone from (Resident #4's DPOA) on 10/25/24. RN E and RN F were asked if updated/new consents are obtained when psychotropic medication doses are changed and/or annually and both responded no. When queried why the Reason for use (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	listed on the Informed Consent forms for Prozac and Zyprexa did not match the diagnosis/indication for use listed on the HCP order/MAR, an explanation was not provided. Documentation of Resident #4's behaviors and behavior monitoring was requested at this time. An interview was completed with the Director of Nursing (DON) and facility Administrator on 4/14/26 at 12:17 PM. When queried regarding Resident #4's psychotropic medications and the listed indications/diagnoses for use, the DON verbalized that the diagnosis of dementia with psychosis was added in 2025. When queried why the diagnosis was added, the DON indicated the Resident had behaviors. Documentation showing the reason for diagnosis was added was requested at this time. Review of Point of Care History documentation from 1/1/26 to 4/14/26 revealed documentation of behaviors two times. On 1/6/26, Resident #4 displayed crying/tearfulness and on 3/31/26 they displayed crying/tearfulness with Sad/pained/worried face expressions. No additional documentation was received from the facility.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and operationalize policies and procedures to ensure that informed consent was obtained prior to initiation of psychotropic medications for one resident (Resident #2) of five residents reviewed for unnecessary medication use. Findings include:Resident #2:Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses which included generalized anxiety disorder and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to total assistance to complete Activities of Daily Living (ADLs) with the exception of supervision/set up for oral care and eating. The MDS further detailed the Resident displayed no behaviors. Review of Resident #2's Electronic Medical Record (EMR) revealed a care plan entitled, Psychotropic Drug Use: (Resident #2) is at risk for adverse consequence from receiving psychotropic medication: Lamictal (anticonvulsant medication frequently used as mood stabilizer in the treatment of bipolar disorder), Buspar (medication used to treat anxiety), Lexapro (medication used to treat depression and generalized anxiety) (Start Date: 2/11/26; Edited: 4/6/26). Review of Resident #2's Health Care Provider (HCP) orders and Medication Administration Record (MAR) revealed the Resident was receiving the following psychotropic medications and dosages:- Buspar 5 milligrams (mg) three times a day (Start Date: 2/6/26)- Lamictal 25 mg daily (Start Date: 2/6/26)- Lexapro 10 mg daily (Start Date: 2/23/26)A review of scanned documentation in Resident #2's EMR revealed an Informed Consent/Risk Benefit Analysis form. The form specified, In order to protect our residents from harm. it is sometimes necessary to utilize medication interventions. Ordered/Prescribed Medication: Lamotrigine (Lamictal). Buspirone (Buspar), Hydroxyzine (Vistaril used to treat anxiety, manage chronic itching, and as a sedative) . The form was signed by Resident #2's Durable Power of Attorney (DPOA) and a facility RN I on 2/6/26. The Physician Signature area of the form was blank. An interview was conducted with Social Service Registered Nurse (RN) E on 4/14/26 at 2:14 PM. When queried regarding consents for psychotropic medications, RN E responded that each psychotropic medication a resident received should be included on the consent form. When queried if new/updated consents are obtained when psychotropic medication doses are changed, RN E responded they are not. RN E was then asked to review consent obtained for Resident #2's psychotropic medications. RN E reviewed the Resident's EMR and the Informed Consent/Risk Benefit Analysis form dated 2/6/26. When asked, RN E confirmed the consent did not include Lexapro. After reviewing the Resident's EMR further, RN E verbalized the a consent not completed for Lexapro. RN E was asked if a consent should have been obtained prior to initiation of the medication and responded that it should have been. When asked if Resident #2 had been seen and/or evaluated by mental health care service provider, RN E responded that they had contacted them and it was in process. On 4/14/26 at 3:35 PM, an interview was completed with the facility Administrator. When queried if consents should be obtained for psychotropic medications prior to initiation of medication therapy, the Administrator verbalized consent should be obtained. The Administrator was informed Resident #2 was receiving Lexapro and did not have a consent. The Administrator verbalized that consent should have been obtained prior to therapy initiation. No further explanation was provided. A policy/procedure related to informed consent for psychotropic medication therapy was requested at this time but not received by the conclusion of the survey.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a restorative nursing program and ensure coordination with therapy services for one resident (Resident #6) of one resident reviewed for limited Range of Motion (ROM). Findings include:Resident #6: On 4/13/26 at 11:16 AM, Resident #6 was observed participating in an activity in the dining room. Resident #6 was in a highbacked wheelchair with both of their lower extremities positioned on the footrests of the wheelchair. Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, saddle embolus (blood clot) of pulmonary artery, right and left foot drop foot contractures. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, had impaired ROM in both lower extremities, and was dependent upon staff for bathing, toileting, and transferring. The MDS further detailed the Resident was not receiving any therapy and/or restorative nursing services. Review of Resident #6's care plans in the Electronic Medical Record (EMR) revealed the Resident did not have a care plan and/or Health Care Provider (HCP) order in place pertaining to their bilateral foot drop contractures, ROM, and/or Restorative Nursing services. Review of documentation in Resident #6's EMR revealed the following related to ROM and/or Restorative: - 3/29/25 at 1:59 PM: Resident. expresses would like therapy to strengthen legs and improve bilateral foot drop. Explained that this would be available depending on (insurance) benefits, otherwise we are happy to offer the restorative program. (Resident #6) verbalizes understanding and will work with restorative for now. - 7/10/25 at 2:09 PM: Type of Care Conference: Quarterly. Therapies receiving: None. How can we better meet your needs? Wants to be able to stand, this nurse spoke to resident and family about restorative and disease progression. - 4/15/26 at 9:48 AM: Nursing. Staff in and applied boots to residents' feet bilaterally. Resident complaining of pain and wanted boots removed, boots removed per resident's request. Approximately 2 minutes of boots applied before removed. On 4/15/26 at 8:56 AM, an interview was completed with Restorative Registered Nurse (RN) F. When queried if Resident #6 had bilateral foot drop contractures, RN F stated, Yes. RN F was asked if Resident #6 was receiving Restorative Nursing services to prevent worsening of contractures and pain associated with contractures and replied, (Resident #6) is not in the restorative program anymore. When asked why the Resident was no longer receiving Restorative Nursing Services, RN F replied, (Resident #6) didn't want to do it. When queried regarding documentation pertaining to Restorative Nursing, RN F revealed they complete a monthly Restorative Assessment for Resident's receiving Restorative. Resident #6's EMR was reviewed with RN F at this time and revealed the most recent Restorative assessment was completed on 7/23/25. Review of the assessment detailed the following: 7/23/25. Monthly Restorative Summary. Description: June. What restorative program: ROM. Plan description: BLE (Bilateral Lower Extremities) -Quad sets, ankle pumps-work on flexion and extension, leg lifts. Do 3 sets of 15 reps each exercise. 1# AW (marches, kickout, side steps) 1# dumbbells (curls, arm raises) Green/blue t-band resistance around knees (may use ball for ball squeezes). Goal Description: Maintain current level of function. Monthly summary/evaluation of resident's progress Resident refusing w/ multiple attempts and multiple days noted. Educated resident on importance of participation in order to maintain current level of function and independence, resident understood but continued to participate in program. Continue w/ present goal? Change Goal? No, see above. Discharge. When queried, RN F revealed the Resident was discharged from Restorative Nursing Services in July 2025. On 4/15/26 at 9:35 AM, an observation and interview was completed with Resident #6 in their room. Certified Nursing Assistant (CNA) P and CNA Q were present in the room and had just assisted the Resident to bed from their wheelchair utilizing a mechanical lift. The Resident was positioned on their back and their toes on both feet were pointed straight down, away from their head with the top of their foot level with the top of their leg. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When queried if they were receiving Therapy services, Resident #6 responded they were not. When asked if they were able to move and flex their ankle, Resident #6 lifted their entire leg slightly but did not flex or move their ankle. Ankle flexion and extension were demonstrated to the Resident. When asked if they were able to flex or move either of their ankles, Resident #6 stated, Mine don't do that. When queried if facility staff work with them and move/stretch their ankles for them, Resident #6 replied, I don't know. When asked if they want staff to work with them and move their ankles and joints so they do not become stiffer, Resident #6 stated, Yes. CNA P and CNA Q were queried if Resident #6 was receiving Restorative Nursing services and both responded they were not. When queried regarding Resident #6's Passive Range of Motion (PROM), CNA P attempted to flex both the Resident's feet upward with minimal movement noted. Resident #6 verbalized pain with gentle, minimal PROM attempt. When queried, both CNA P and CNA Q verbalized Resident #6 has pain with any movement. A pair of hard bottom PRAFO (Pressure Relief Ankle Foot Orthosis) style contracture boots were observed sitting in the room. An interview was completed with the Director of Nursing (DON) on 4/15/26 at 9:44 AM. The DON was asked when Resident #6 was last evaluated by Physical/Occupational therapy specifically related to contractures and/or ROM. The DON reviewed Resident #6's EMR and verbalized they did not see any documentation from Physical and/or Occupational therapy in the Resident's EMR. When queried how the facility assessed Resident #6's contractures to ensure they were not worsening, without therapy evaluation and measurement of contractures, the DON did not provide an explanation. Review of Point of Care task completion in Resident #6's EMR from 3/1/25 to 10/1/25 revealed documentation for number of minutes and how the Resident tolerated Active Range of Motion (AROM). The Resident did not have a task for PROM and/or PRAFO boot application. The documentation did not indicate what specific AROM was being completed and how often the task was supposed to be completed. Review revealed the task was completed three times per week on average. There was no documentation of refusal in the EMR. An interview was completed with Therapy Director M on 4/15/26 at 10:29 AM. When queried regarding Resident #6 including initial evaluation and measurements of contracture and ROM, Director M stated, We (therapy services) haven't seen (Resident #6) and didn't do an assessment for initial evaluation. Director M was asked who does the ROM evaluation for the MDS assessment and replied, (RN F) does. When asked about the Restorative Nursing program at the facility and Therapy services involvement including contracture management and prevention, Director M revealed Therapy does not see every resident for an evaluation as it is based upon the individual resident's insurance. With further inquiry, Director M revealed Therapy does not implement a restorative program for residents they do not see/treat but will recommend Restorative Nursing services following therapy service discontinuation if appropriate. When queried if Therapy staff are the most qualified to provide input related to appropriate interventions for contracture prevention and management, Director M confirmed they were. When asked how residents who do not receive therapy obtain Restorative Nursing services with appropriate interventions for contracture prevention/management without Therapy input, Director M indicated they are available for questions. On 4/15/26 at 10:35 AM, Resident #6 was observed in their room in bed speaking with two visitors. The PRAFO boots were sitting on the wheelchair in the room. An interview was completed with Restorative CNA O on 4/15/26 at 10:40 AM. When queried regarding Resident #6, CNA O revealed they had not seen Resident #6 for Restorative in a long time but were unable to recall a specific date. With further inquiry, CNA O verbalized the Resident had bilateral foot drop contractures when they were receiving Restorative. An observation of Resident #6 was completed with CNA O at this time. The Resident's feet and ankles remained in the same position as prior observation and the PRAFO style boots remained in the chair. While in the room, Resident #6's family member was overheard telling Resident #6, Need to get rid of your ballerina feet. The family member then asked CNA O why Resident #6 was not wearing the PRAFO boots and CNA O responded that the Resident doesn't like to wear them. After exiting the room, CNA O was queried regarding the PRAFO boots and revealed the Resident does not like to wear them (continued on next page)

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	235192	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mymichigan Skilled Nursing Facility	805 West Cedar Standish, MI 48658

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because they hurt. A follow-up interview was conducted with RN F on 4/15/26 at 10:48 AM. When queried why Resident #6 did not have a care plan in place for bilateral foot drop contractures, RN F stated, There should be. RN F reviewed Resident #6's EMR, confirmed there was no care plan, and stated, I messed up. When asked about the PRAFO style boots observed in the Resident's room, RN F reviewed the Resident's EMR and verbalized there was no order and no care plan in place for PRAFO boots. RN F stated, I'm not sure where they came from and indicated the Resident's family will bring things into the facility from home. With further inquiry, RN F went to speak to Resident #6 and their family regarding the boots. RN F returned and stated the family brought in the boots when (Resident #6) first came in. When asked why there was no documentation regarding the boots, an explanation was not provided. RN F was then asked who completes section GG on the MDS assessment and replied, I do. When queried if therapy services ever completes the section of the MDS, RN F revealed they do not as they are part of the hospital side of the facility. RN F was asked to clarify the reason Resident #6's Restorative Nursing was discontinued and indicated the Resident had refused to participate. When queried if Resident refusals should be documented, RN F verbalized they should. Resident #6's Point of Care documentation for Restorative Nursing from 3/1/25 to 10/1/25 was reviewed with RN F at this time. When queried regarding the lack of documentation of care refusals, RN F confirmed and indicated staff also document on a paper form. RN F proceeded to look for the paper documentation and stated, I cant find the paper documentation for Restorative for (Resident #6). When queried regarding the Resident only having AROM documentation, RN F confirmed. When asked if Resident #6 had AROM in their bilateral ankles with their known foot drop contractures, RN F indicated they did not have much AROM if they had any. When asked why PROM was not implemented, RN F was unable to provide an explanation. When asked if PROM would be appropriate for an individual with foot drop contracture, RN F confirmed it would be. RN F was then asked if they agreed it appeared that Resident #6 had AROM in July 2025 when Restorative Nursing was discontinued does not have any AROM in their ankle at this time when asked to demonstrate, RN F stated, I can't argue that. No further explanation was provided. An interview was completed with the DON on 4/15/26 at 11:48 AM. When queried regarding Resident #6's bilateral foot drop contractures including lack of qualitative measurement assessment of ROM and lack of ongoing Restorative/ROM to prevent worsening, the DON verbalized understanding of concern. On 4/15/26 at 1:38 PM, an interview was completed with the Administrator. When queried regarding Resident #6's bilateral foot drop contractures including lack of measurements/monitoring and interventions to prevent worsening including Restorative Nursing Services, the Administrator verbalized understanding. No further explanation was provided. Review of facility policy/procedure entitled, Restorative ADL (Dated: 1/23) revealed, Restorative ADL Program is to provide the opportunity for patients/residents in long term care to attain their highest level of independence in self-care. Restorative programs will be conducted once per day, 3 to 5 days/week. Other staff must be familiar with the patient/resident POC status to follow through on off days. The Restorative Nurse or designee will evaluate through a screening process or referred by therapy services for continuation of strengthening ADL care. Potential Candidates: Patients with physical limitations which include, but are not limited to: Decreased range of motion.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate monitoring for the presence of potential adverse consequences of anticoagulation medication therapy for one resident (Resident #6) of two residents reviewed for anticoagulation medication therapy. Findings include:Resident #6: Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, right and left foot drop foot contractures, and saddle embolus (blood clot) of pulmonary artery. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to total assistance to complete Activities of Daily Living (ADLs) with the exception of oral care and eating. Review of Resident #6's Health Care Provider (HCP) orders and Medication Administration Record (MAR) revealed the Resident was receiving Eliquis (anticoagulant or blood thinner medication) 5 milligrams (mg) twice a day (BID) (Start Date: 3/24/25). A review of Resident #6's care plans revealed the resident did not have a care plan in place related to anticoagulation therapy and/or monitoring. Review of Resident #6's MAR, Treatment Administration Record (TAR), and note documentation in the EMR revealed no documentation of monitoring for signs/symptoms of potential side effects of treatment including bleeding. An interview was completed with MDS Registered Nurse (RN) F on 4/14/26 at 3:04 PM. When queried regarding Resident #6, RN F confirmed the Resident was receiving an anticoagulant medication. RN F was asked how the facility monitored for signs/symptoms of adverse medication consequences and revealed residents will have a care plan which includes monitoring. When queried regarding a care plan for Resident #6, RN F reviewed the Resident's EMR and verbalized there was no care plan in place. When asked how the facility was monitoring for potential adverse consequences of anticoagulant therapy, RN F verbalized there was no monitoring in place but indicated they would implement a care plan. On 4/14/26 at 3:35 PM, an interview was completed with the facility Administrator. When queried regarding Resident #6 and lack of monitoring for potential adverse effects of anticoagulant medication therapy, the Administrator revealed they were aware of the concern, and it was being addressed. Upon request for a facility policy/procedure related to monitoring for potential adverse consequences of anticoagulant medication therapy, the Administrator revealed they would look but did not believe the facility had a specific policy/procedure. Review of facility policy/procedure entitled, Medication Management Policy and Procedure (Approved: 3/2026) did not include any information related to monitoring for signs/symptoms of potential adverse consequences of medication therapy.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication administration error rate of less than 5% when two medication errors were observed for two residents (Resident #7 and Resident #16) from a total of 32 observations, resulting in a medication error rate of 6.25%. Findings include:Resident #7:On 4/15/26 at 7:27 AM, a medication pass observation for Resident #7 was completed with Registered Nurse (RN) K. RN K was observed preparing Resident #7's medication at the medication cart outside of the Resident's room. While preparing the medications, RN K removed one bethanechol chloride (medication commonly used to treat urinary retention) 10 milligram (mg) tablet from the blister pack and placed in a medication cup. The blister pack had a sticker on it with the instructions, Take on an empty stomach. Resident #7 was able to be visualized from the medication cart in the hallway. A food tray was observed on the overbed table in front of them. RN K proceeded to lock the medication cart and was stopped and asked if they were going to administer all the medications prepared to the Resident. RN K responded they were. RN K was then asked to review the administration instructions on the bethanechol chloride blister packet. RN K remove the medication blister package from the cart and identified the sticker which stated the medication had to be taken on an empty stomach. When queried regarding facility policy/procedure related to administration of medications with specific administration instructions, RN K revealed they were unsure. When asked what they would normally do, RN K responded they would still give the medication. At this time, an interview was completed with RN K and the Director of Nursing (DON). The DON was informed of Resident #7's bethanechol chloride medication and the instructions on the blister packet specifying the medication should be administered on an empty stomach. RN K asked the DON what they should do and the DON stated, Hold the medication and Inform the doctor. Resident #16:A medication pass observation for Resident #16 was completed on 4/15/26 at 8:19 AM with RN J. RN J was observed preparing Resident #16's medication at the medication cart. RN J removed one bethanechol chloride 5 mg tablet from the blister pack and placed in a medication cup. A sticker with the instructions, Take on an empty stomach was noted on the medication blister pack. RN J proceeded to enter Resident #16's room and administer their medications. After administration, RN J was queried regarding the sticker on the blister pack for Resident #16's bethanechol chloride. RN J proceeded to remove the blister pack from the medication cart and review the administration instructions on the sticker. RN J was asked if Resident #16 ate breakfast and replied, Yes. When asked if they knew the reason bethanechol chloride should be taken on an empty stomach, RN J revealed they would need to look up the medication. RN J verbalized they were administering the medication at the scheduled time, and they would speak to the DON as the administration times may need to be adjusted. At 8:41 AM on 4/15/26, the DON was informed of the medication pass observation completed with RN J for Resident #7. When queried regarding the mediation instructions specifying the medication should be given on an empty stomach and the Resident having ate breakfast, the DON verbalized understanding of the medication error but did not provide further explanation.Note: Bethanechol chloride should be taken on an empty stomach for optimal absorption and to reduce potential nausea/vomiting.An interview was completed with facility consultant Pharmacist L on 4/15/26 at 9:11 AM. Pharmacist L revealed facility staff informed them of the medication administration concern related to bethanechol chloride administration. Pharmacist L verbalized that both Resident #7 and #16 have had the medication scheduled at the same time for as long as they had been at the facility and they were unaware of any adverse effects. When queried why the label on the medication packet specified to take the medication on an empty stomach, Pharmacist L replied, We have to put it on there. That is the manufacturers' recommendation. No further explanation was provided. Review of facility policy/procedure entitled, Medication Management Policy and Procedure (Approved 3/2026) revealed, All medications will be administered only upon a clear and complete order and in a safe, accurate manner. 17. Personnel administering (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications shall refer to an approved reference when unfamiliar with the pharmacology, potential side effects and contraindications. 20. Preparation for medication administration. Read the label on each medication three (3) times and check with medicine card: ˆ Before removing from the cart ˆ Before pouring the drug ˆ Before replacing the container. Remember always!! ˆ Right Patient ˆ Right Drug ˆ Right Dose ˆ Right Route ˆ Right Time.