STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235201	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munson Healthcare Crawford Continuing Care Center	1100 Michigan Avenue Grayling, MI 49738

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document collaboration among the interdisciplinary team (IDT) and to offer and provide inclusion of resident's or their representatives in the quarterly review of the comprehensive care plan for three Residents (#5, #7 and #13) of 12 residents reviewed and affecting all 19 residents receiving long-term care of a total of 27 residents residing in the facility.Findings include:Resident #5 (R5) During a telephone interview on 3/23/2026 at 12:10 PM, R5's Medical Durable Power of Attorney (MDPOA), Family Member (FM) D reported she was unable to visit R5 as often as she would like but she was able to visit a couple of time per year. When asked if she was able to attend R5's care conferences, FM D reported she was unaware of when R5's care conferences were held and had not been alerted or invited to review the plan of care with the IDT. When asked if she would like the opportunity to meet with the IDT for review of the plan of care, FM D stated, I like to know what is going on with her health and so on, so yes, I would like the opportunity to hear what everyone has to say. Review of the electronic medical record (EMR) revealed R5 was admitted to the facility on [DATE] and had diagnoses including diabetes, chronic kidney disease and dementia. Review of R5's comprehensive care plan revealed multiple care areas of focus including the risk for alteration in nutrition; risk for falls/injury; risk for alteration in activity participation; risk for alteration in skin integrity; risk for pain; and risk for alteration in ADL (Activities of Daily Living) completion. Further review of the care plan revealed, [R5] requires long-term care due to multiple health conditions and is no longer able to care for herself and needs significant assistance for completion of ADLs. Revision on: 3/25/2025. [R5's] goals will be met by staff while respecting her wishes and dignity to the extent possible. Revision on 3/19/2026. Admit/DC planner to review LTC planning with [MDPOA] during comprehensive assessments and PRN [as needed]. Revision on 3/21/2025. During an interview on 3/24/2026 at 12:20 PM the facility Social Services Designee, Staff C was queried regarding the facility procedure for holding care conferences. Staff C stated, We're behind on those. Staff C reported the facility MDS Coordinator, Registered Nurse (RN) A scheduled the resident's care conferences. Staff C reported she provided a quarterly review for social services but did not meet with other members of the IDT to review the care plan as a whole for long-term care residents. During an interview on 3/24/2026 at 12:30 PM, RN A was asked about the process for reviewing the plan of care with the IDT, residents and resident's representatives. RN A reported formal care conferences were not held for long-term care residents. RN A stated, We aren't doing them right now. My understanding is the care plan just needs to be adjusted as needed. When asked the process for (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the plan of care, RN A reported she reviewed the care plans following quarterly MDS (Minimum Data Set) assessments and determined the appropriateness of the plan based on data entered in assessment by the IDT. RN A reported there was no need to discuss the plan with IDT, resident or resident representatives for long-term care residents because, We are a very small facility. We see people all the time. Everyone knows. Further review of R5's EMR from 10/01/2025 through 3/24/2026 revealed no documentation to indicate collaboration among the IDT or review of the comprehensive plan of care with the Resident or her DPOA. Review of R5's comprehensive care plan revealed all entries to the care plan were completed by RN A and there was no notation or indication the IDT reviewed their respective care areas. Resident #7 (R7) A review of the EMR revealed R7 was admitted on [DATE]. R7's care plan indicated problems including Alzheimer's disease with other behavioral disturbances – agitation, variable communication skills, altered safety awareness, episodes of incontinence. R7 had many areas of focus and many interventions listed on the care plan. During an interview on 3/24/2026 at 2:58 PM, RN A was asked when the last care conference for R7 had been held. RN A checked the medical record and replied, She (R7) came in on 8/1/2025. We never had one. RN A stated the Durable Power of Attorney (DPOA) was at the facility quite often and the facility communicated with them frequently. When asked where the conversations on R7's plan of care were documented, RN A stated, That would be in the EMR under clinical assessments. This section of the EMR was reviewed by RN A and she stated there was no documentation of a discussion on the plan of care for R7. Resident #13 (R13) A review of the EMR revealed R13 was admitted on [DATE]. R13's care plan indicated problems including Alzheimer's disease along with dementia with agitation, easily anxious, high strung, episodes of agitation. significant decline in status due to fall resulting in. fx (fracture). R13 had many areas of focus and many interventions listed on the care plan. The goals were printed in red color and marked as (OVERDUE). During an interview on 3/24/2026 at 12:37 PM, RN A was asked why the care plan goals were in red and marked as overdue. RN A stated, I update the MDS assessments and then the care plan, and I must have missed the care plan update . RN A also said R13 was admitted in October and probably has not had a care conference since her (R13's) admission. RN A explained R13's son was the activated DPOA and we talk to him all the time.

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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. Based on interview and record review, the facility failed to obtain informed consent for psychoactive medications for one Resident (R10) of five residents reviewed for psychoactive medications.Findings include:A review of R10's electronic medical records (EMR) indicated an admission into the facility on 2/21/2024 with a primary diagnosis of severe vascular dementia with behavioral disturbance (a cognitive decline caused by reduced blood flow to the brain, damaging brain tissue and affecting memory, thinking and behavior). A review of the most recent Minimum Data Set (MDS) assessment with a submission date of 3/16/26 revealed R10 had severely impaired cognition and Section C indicated resident is rarely/never understood. The medical record documented R10 had an appointed responsible party for health care and financial decision making.A review of R10's 'Physician Orders' for March 2026 indicated the antipsychotic medication quetiapine fumarate 25 mg (milligrams) was prescribed and initiated on 7/10/25 and the antidepressant medication sertraline HCl 25 mg was prescribed and initiated on 1/9/26.A review of R10's EMR revealed no evidence R10's responsible party had given written or verbal consent for the administration of an antipsychotic or antidepressant nor were they informed of the potential side effects/adverse reactions.On 3/25/2026 at approximately 9:00 AM, consents for Quetiapine Fumarate and Sertraline HCl were requested. During an interview on 3/25/2026 at 9:30 AM, the Director of Nursing (DON) stated, We do not have a consent for those meds.The facility policy titled Chemical Restraints-Psychoactive Medications dated as last approved 3/28/25 was reviewed. The policy read in part, .The resident or responsible party will be notified of the drug order and documentation will reflect this. The facility policy titled Informed Consent - Diagnostic or Therapeutic Procedures and Treatments and last reviewed 6/4/2025 was reviewed and read in part, The patient's right to informed consent for invasive procedures, high-risk therapies/drugs, and experimental treatments will be supported by the providers and staff. Consents for Treatment, must be signed by the patient for therapeutic and diagnostic procedures where disclosure of significant medical information, including major risks involved, would assist the patient in making an educated decision about whether or not to undergo the proposed procedure.

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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. Based on interview and record review, the facility failed to provide written notification of transfer or discharge and the facility bed hold policy for three Residents (#3, #6 and #32) of three residents reviewed for hospitalization. Findings include: Resident #3 (R3 During a room visit on 3/23/2026 at12:06 PM, R3 stated she had been out to hospital when she had experienced chest pain. A review of R3's medical record revealed the resident was sent to the Emergency Department on 2/7/26. The medical record included a facility Transfer Notice dated 2/7/26 with a reason for transfer, transfer location, and signature of the RN completing the form. The space designated for acknowledgement of receipt was unsigned and undated. The medical record also did not contain documentation that an explanation of the facility bed hold policy had been given to R3 or R3's responsible party. Resident #6 (R6) A review of R6's electronic medical record EMR) revealed the resident was transferred to the Emergency Department on 1/05/26 for evaluation of an acute episode of shortness of breath. Further review of the EMR revealed a Transfer Notice, dated 1/05/2026, indicating the reason for the transfer as, Medically unstable and needs medical treatment at another facility. The Transfer Notice, was signed by a facility nurse and the signature line for acknowledging receipt of the notice was blank. A handwritten note at the bottom of the Transfer Notice, read, Voicemail left for [resident representative] 1/5/26 [at] 1935 PM [7:35 p.m.]. It was noted there was no language included in the Transfer Notice, of the facility policy on bed holds or any indication on the form of R6 or R6's representative's provision of the written notice. Resident #32 (R32) A review of R32's EMR revealed the resident was transferred to the Emergency Department on 1/18/2026 for evaluation. Further review of the EMR revealed a Transfer Notice, dated 1/18/2026 indicating the reason for the transfer as, other: resident requesting. The Transfer Notice was signed by facility staff on 1/18/2026 and the signature line acknowledging receipt of the notice was blank. It was noted there was no language included in the Transfer Notice, of the facility policy on bed holds or any indication on the form of R32 or R32's representative's provision of the written notice. During an interview on 3/25/2026 at 10:38 AM, Social Services Designee, Staff C, reported she kept a paper file of all Transfer Notices. During review of the paper copies of the facility's completed Transfer Notices(s), Staff C confirmed the forms completed for R3's transfer on 2/07/2026, R6's transfer on 1/05/2026 and R32's transfer on 1/18/2026 did not include a signature acknowledging receipt of the forms or any indication the written forms were provided the resident's or their representatives. Staff C reported she was unaware the notification of transfer needed to be provided in writing then stated, We're not doing that. Staff C reported information of the facility policy on bed holds was provided at the time of admission and was not provided again for transfers to the Emergency Department. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Notice of Transfer and/or Discharge, dated as last reviewed on 7/21/2025, revealed the following: The facility will provide the resident, and/or resident's representative with the appropriate notice of transfer/discharge according to state and federal requirements. The residents and/or representative will be notified of the transfer/discharge and provided with the following information: The reason for the transfer or discharge. The effective date of the transfer or discharge. The location to which the resident is being transferred or discharged . The name, address, and telephone number of the state long-term care ombudsman. The name, address and telephone number of individuals or agencies responsible for the protection and advocacy of mentally ill or developmentally disable individuals. The name, address and telephone number of the state health department agency that has been designated to handle appeals of transfers an

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, monitor and maintain nutritional status of one Resident (R7) of two residents reviewed for nutritional needs.Findings include:Resident #7 (R7)A review of the electronic medical record (EMR) revealed R7 was admitted on [DATE] with a primary diagnosis of Alzheimer's disease. The Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 2 of 15 indicating severe cognitive impairment.On 3/23/2026 at 12:17 PM, R7 was observed at lunch feeding herself with success.During a telephone interview on 3/23/2026 at 2:23 PM, the Durable Power of Attorney said R7 was a very active person in youth and walked several miles a day but was not active now and was gaining weight and might outgrow her clothes.The facility Registered Dietitian (RD) B reviewed R7's nutritional status quarterly. The last progress note from RD B on 2/7/26 read, Note Text: Quarterly dietary review. Resident is receiving a level 7 diet with thin liquids and is tolerating well. Resident sometimes eats meals in her room, in the lobby by the birds, and sometimes the dining room. Resident has a current weight of 126.7 pounds, weight one month ago was 130.4 pounds, weight 3 months ago was 123.3 pounds, and weight 6 months ago was 126 pounds. Resident weight has been overall stable at this time, and skin remains free from pressure related areas at this time. Will continue to follow weight trends and food acceptance records to see if further intervention is needed.On 3/23/26 the weights for R7 were reviewed in the medical record:9/1/2025 = 122.410/1/2025 = 123.311/1/2025 = 127.912/1/2025 = 130.41/1/2026 = 126.73/1/2026 = 135.3No weight was recorded for February 2026 and no reweigh of the 8.6 pound weight gain (a significant 6.7% change since the previous monthly weight) had been taken.R7's care plan included a focus of at risk for alteration in nutrition r/t Alzheimer disease, dementia classified elsewhere with other behavioral disturbances, variable communication skills, hypothryroidism. (sic) . The goal for this focus was (R7) will receive adequate nutrition and her weight will remain stable t/o (by) next review. The only interventions listed to reach this goal were listed as, Monitor and record (R7's) weight. And Provide 7/0 (regular) diet with set up assist as needed.No further RD notes had been recorded and no update to the care plan after the significant weight change had been made.During a telephone interview on 3/25/2026 at 12:00 PM, RD B stated she had not been aware of a weight change for R7 and agreed the facility had not followed the weight procedure.The facility provided the policy titled, Resident Weight Procedure dated as created 1/24/2024. This policy read in part, .Long term care residents will have their weight obtained by certified or licensed staff at monthly intervals unless more frequent monitoring is determined. A weight difference of 5 pounds +/- during a monthly weight will require a re-weight within 24 hours.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review, the facility failed to provide dining adaptive equipment for three Residents (R28, R30 and R36) of four residents reviewed for dining assistive devices. Findings include: On 3/23/2026 at 12:34 PM, lunch service was observed in the dining room.R28 was observed feeding himself. His hand was shaking and the food on his spoon was not all going into his mouth. Spills were present down the front of the clothing protector R28 was wearing. The meal tray card for R28 included instructions typed in capital letters and red ink indicating LARGER SPOON. The spoon R28 was using was not larger but was a standard teaspoon size. When the dining room staff were asked about the spoon, Certified Nursing Assistant (CNA) E said he should have received a larger spoon.R30 was observed in the dining room with his lunch. The meal tray card for R30 included instructions for a SMALL DIAMETER STRAW which was typed in capital letters and red ink. R30 did not have a straw . CNA G stated R30 did not geta smaller straw and it had been missed. CNA G said R3 needed a smaller straw as he drinks too fast with the larger straw.During an interview on 3/24/2026 at 10:04 AM, Dietary Manager (DM) F agreed the staff should be following the instructions on the meal tray cards.On 3/24/2026 at approximately 1:00 PM, R36 was observed eating lunch in his room. The meal tray card for R36 included instructions for BUILT UP FOAM FOR UTENSILS which was typed in capital letters, in red ink, and was further highlighted in yellow. R36 had regular utensils without built up foam to facilitate his grip. R36 was struggling to feed himself. R36 was asked if he did better with the foam. He replied, Yes, I need that. I did not get it this morning at breakfast either.During an interview on 3/24/2026 at approximately 1:15 PM, DM F' stated the therapy department had been working with R36 and had supplied the built-up foam handled utensils. A facility policy Scope of Services for Rehabilitation Services dated as last revised 1/17/2024 read in part, Rehabilitation Services are provided in accordance with the facility's mission and plan for the provision of care. and will provide Equipment Training and Recommendations.Adaptive aids for activities of daily living.