STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235213	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegan County Medical Care Facility	3265 122nd Ave R2 Allegan, MI 49010

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was transmitted to the Centers for Medicare and Medicaid Services (CMS) timely for 1 (Resident #21) of 1 resident reviewed for resident assessments, resulting in the potential for an inaccurate reflection of the resident's status.Findings include:Resident #21Review of an admission Record revealed Resident #21 was a female, originally admitted to the facility on [DATE].A review of Resident #21's electronic medical record (EMR) MDS screen revealed that Resident #21's 12/9/25 Quarterly MDS was completed. It was not marked as accepted to indicate that it had been transmitted to CMS.In an interview on 2/19/26 at 12:47 PM, MDS Coordinator (MDSC) Y reported that Director of Nursing (DON) B had previously been the MDS Coordinator and was still the one who exported (referring to transmitting) the completed MDS assessments to CMS.In an interview on 2/19/26 at 12:51 PM, DON B reviewed Resident #21's 12/9/25 Quarterly MDS with this surveyor and confirmed that it had not been transmitted to CMS. DON B reported the Quarterly MDS on 12/9/25 was not closed correctly and she had not caught that error and missed transmitting the MDS to CMS. DON B reported if an MDS was not submitted timely, CMS may not have an accurate reflection of the resident's status.In an interview on 2/19/26 at 3:46 PM, MDSC Y was queried as to how she tracked the MDSs in the system (to ensure all MDSs were transmitted timely). MDSC Y reported that was a question for DON B.In an interview on 2/19/26 at 3:55 PM, DON B was queried as to how she tracked the MDSs in the system (to ensure all MDSs were transmitted timely). DON B reported that was a question for MDSC Y.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 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. Based on observation, interview, and record review, the facility failed to provide activities of daily living (ADL) care (to include nail care) to a dependent resident for 1 (Resident #3) of 1 resident reviewed for ADL care resulting in dirty nails and the potential for feelings of embarrassment.Findings include:Resident #3Review of an admission Record revealed Resident #3 was a female, with pertinent diagnoses which included: hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side; vascular dementia, moderate with psychotic disturbance (abnormal thinking and loss of contact with reality); and major depressive disorder, recurrent, moderate. Review of a Minimum Data Set (MDS) assessment for Resident #3, with a reference date of 2/3/26 revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #3 was moderately cognitively impaired. Further review of said MDS revealed Resident #3 had a functional limitation in range of motion impairment on one side of upper extremity and impairment on both sides of lower extremity.Review of a current Care Plan for Resident #3 revealed a focus of, (Resident #3) had an ADL self-care performance deficit r/t (related to) Confusion, Dementia, Fatigue, Hemiplegia d/t (due to) dx (diagnosis) of hx (history) of TIA (transient ischemic attack - stroke), cerebral infarction (blood flow to part of the brain is blocked), hemiplegia affecting left side, dysphagia (swallowing difficulty), COPD (chronic obstructive pulmonary disease) with a date initiated of 11/11/2022 and a revision date of 3/1/23 and care planned interventions which included, BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse with a date initiated of 11/11/22.In an observation and interview on 2/18/26 at 12:08 PM, Resident #3 reported she liked having her nails done. It was noted that Resident #3's nails, specifically the thumbnail and pointer finger on the right hand were caked with black debris underneath the nails.In an observation on 2/19/26 at 9:29 AM, Resident #3's nails were observed. Resident #3's nails, specifically the thumbnail and pointer finger on the right hand, were caked with black debris underneath the nails.In an interview on 2/19/26 at 9:50 AM, Certified Nurse Aide (CNA) AA reported Resident #3 did not refuse nail care and that she liked getting nail care.In an observation and interview on 2/19/26 at 1:54 PM, CNA L observed Resident #3's nails with this surveyor and reported that Resident #3's nails needed to be cleaned. CNA L reported nail care was typically provided when it was noticed that they were dirty.In an interview on 2/19/26 at 2:24 PM, Director of Nursing (DON) B reported residents' nails should be cleaned on the resident's shower day at least weekly and should be cleaned whenever they are dirty. DON B reported if nails were visibly dirty, they should absolutely be cleaned.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure that 1.) a complete physician order was in place for BiPAP (bilevel positive airway pressure - a noninvasive breathing device that helps people with breathing difficulties breathe more easily) therapy and 2.) BiPAP therapy administration was documented for 1 (Resident #18) of 1 resident reviewed for respiratory care, resulting in an incomplete reflection of the resident's care.Findings include:Resident #18Review of an admission Record revealed Resident #18 was a female, with pertinent diagnoses which included: obstructive sleep apnea (breathing repeatedly stops and starts during sleep due to the muscles in the back of the throat relaxing and causing airway blockage).Review of a current Care Plan for Resident #18 revealed, (Resident #18) has obstructive sleep apnea and uses a BiPap with oxygen while asleep with a date initiated of 7/24/23.Review of a current Physician's Order revealed, BiPap setting: Min (minimum) 4.0 (cmH2O - centimeters water)-Max (maximum) 8.0 (cmH2O), Auto 5 (cmH2O), pressure 13.3 (cmH2O), min 9.3 (cmH2O), PS (pressure support) 4.0 (cmH2O) verbal active 4/17/2023Review of a current Physician's Order revealed, BiPap clean daily and store per protocol, in the morning related to OBSTRUCTIVE SLEEP APENA.verbal active 4/12/23On 2/19/26 at approximately 9:45 AM, Resident #18's Order Summary was reviewed and revealed no physician's order for the time or frequency of administration of BiPAP therapy for Resident #18.Review of Resident #18's January, 2026 MAR TAR (medication administration record treatment administration record) revealed no documentation of Resident #18's BiPAP therapy administration.Review of Resident #18's February, 2026 MAR TAR from 2/1/26 - 2/18/26 revealed no documentation of Resident #18's BiPAP therapy administration.In an interview on 2/19/26 at 11:09 AM, Director of Nursing (DON) B reviewed Resident #18's Physician Orders with this surveyor and reported there was no order in place for Resident #18 regarding the time or frequency of administration of BiPAP therapy. DON B reported without the complete order, nursing staff wouldn't know what to do for Resident #18. DON B reported the importance of a complete order was to have all the information on how to care for the resident and so the therapy was completed. DON B reported Resident #18 had respiratory failure and if the BiPAP therapy didn't get done, Resident #18 would have trouble breathing at night.In an interview on 2/19/25 at 11:15 AM, Registered Nurse (RN) P reported Resident #18 would normally put her BiPAP on when she got ready for bed. RN P reported without a physician's order, nursing staff would not know specifically when Resident #18 needed the BiPAP therapy. RN P reported there should be a section in the medical record to check off when the BiPAP therapy was administered.