STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235238	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evangelical Home - Saline	440 W Russell Saline, MI 48176

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 27446 This citation pertains to intake number MI00150684. Based on observation, interview, and record the facility failed to document one out of three resident's (Resident #3) condition per professional standards of practice, resulting in the potential for a delay in treatment. Findings Included: On 3/11/2025 at 2:50 PM, Resident #3 (R3) was observed in her room lying in bed. R3 stated she that about three weeks ago she had a stroke. R3 said she felt weird, and was not able to speak. R3 was noted to have a slight speech impairment, but was understood. In an interview on 3/12/2025 at 11:11 AM, Certified Nurse Aid (CNA) C stated that on 2/11/2025 R3 seemed off around breakfast time, and stated R3's speech was slurred, was not swallowing food, was drooling food on her gown and face, eating messy, and her speech was slurred enough that is was noticed. CNA C said R3 was pocketing food (not chewing or swallowing the food but holding it in the cheek), was not able to be verbally understood, could not understand what the bed remote was for, and said the symptoms were all new. CNA C said Licensed Practical Nurse (LPN) D was notified by several CNAs that something was wrong with R3, and R3 was not at her baseline. CNA C stated that the response she received from LPN D was that he would check on R3 later, and LPN D did not go right away into R3's room. CNA C said then LPN E was made aware of R3's changes. In an continued interview CNA C stated that R3 told LPN E that she felt ok, but was having a hard time getting words out. CNA C said LPN E then called the Nurse Practitioner (NP). CNA C said herself and two other CNAs kept telling LPN D that R3 was getting worse. CNA C also stated that LPN E went and reported R3's symptoms to LPN F, who was the Unit Manager. Several attempts were made on 3/12/2025 at 10:38 AM to contact LPN E but was not successful. In an interview on 3/12/2025 at 11:35 AM, LPN F stated that a CNA told her on 2/11/2025 R3 was acting different. LPN F said she assessed R3's speech was delayed, but no other symptoms were observed. LPN F said the NP wanted the Tamaflu (medicine to treat and prevent the flu) stopped because the medication can cause stroke like symptoms. LPN F said on 2/11/2025 in the AM R3 was still a bit slow with her words. LPN F said she wrote an order for neurological (neuro) checks and blood pressure checks to be done every four hours. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN F said the Treatment Administration Record (TAR) had a place for the nurse to sign that the neuro checks were done. LPN F stated LPN D did not sign that he had done the neuro checks. LPN F said the actual neuro checks or assessment were documented on a piece of paper, and that paper was scanned into the resident's electronic medical record (EMR), and then destroyed. LPN F said R3's neuro checks were not scanned into R3's EMR, and therefore she was not able to state the neuro checks were ever done. LPN F said she only saw R3 one time in the morning on 2/11/2025, and not again on that day. Record review of R3's EMR revealed that on 2/11/2025 there were no progress notes documented at all during the dayshift. The only progress note that was documented was documented by LPN G on 2/11/2025 at 6:17 PM and stated as follows: Health Status Note, Note Text: Entered resident room at 1530 (3:30 PM) VS (vital signs) B/P (blood pressure) 184/98 P (pulse) 82 R (respirations) 18 T (temp) 97.1 SPO2 (oxygen level) 96% .Noticed slurred speech. Resident (R3) denies numbness, tingling, headache, hand grips equal, able to swallow without difficulty .NP called informed of condition. Stated to send resident to hospital for possible CVA (stroke) .Resident sent is ambulance at 1605 (4:05 PM) . In an interview on 3/11/2025 at 3:35 PM LPN G said she had just come into work. LPN G said she went to R3 right away and sent her out to the hospital pretty fast. LPN G said R3's speech was slow and slurred, she was confusion. LPN G said she was given report from LPN D who told her about R3's symptoms. LPN G said when she assessed R3 what she found (symptoms) was bad, and stated she spoke with the NP who ordered R3 to be sent out. Per review of the progress notes documented by LPN G, R3 was sent out to the hospital within 35 minutes of LPN G first assessing her. In an interview on 3/12/2025 at 9:15 AM, LPN D stated he was not sure why he did not document any progress notes on R3 on 2/11/2025. LPN D said he did talk to LPN E who told that R3 was talking funny and had slurred speech. LPN D said LPN E assessed R3 and phone the NP who gave orders to take R3's blood pressure every fours hours. LPN D again could not explain why he did not document any progress notes regarding R3's condition on 2/11/2025. LPN D said he was gone from the facility when R3 was sent out to the hospital, In an interview on 3/12/2025, Director of Nursing (DON) B stated there was a lack of documentation regarding R3's condition on 2/11/2025.